MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES CONSOLIDATION REQUEST FOR WAIVER RENEWAL

I. Introduction

A. Overview of Request for Waiver Renewal

California is requesting renewal of the Medi-Cal Specialty Mental Health Services Consolidation waiver. The specifics of the renewal request begin on page 6. In discussing the waiver, the terms “initial waiver period” and “first waiver renewal” (or “modified waiver”) and “second waiver renewal” and "third waiver renewal" are used. The initial waiver period is used to mean the Medi-Cal Psychiatric Inpatient Hospital Services Consolidation waiver program that was in effect from March 17, 1995 until the waiver was renewed on September 5, 1997. The first waiver renewal or modified waiver refers to the waiver that was modified and renamed the Medi-Cal Specialty Mental Health Services Consolidation and in effect from September 5, 1997 through November 19, 2000. The second waiver renewal refers to the current waiver period, effective November 20, 2000, through November 19, 2002. The third waiver renewal period refers to the current request for renewal of the Medi-Cal Specialty Mental Health Services Consolidation waiver that would run from November 20, 2002 to November 19, 2004.

B. Program Design for Medi-Cal Mental Health Managed Care

The design of managed care for California’s Medi-Cal mental health program includes three steps, to be phased in over several years. Medi-Cal Psychiatric Inpatient Hospital Services Consolidation was the first phase, based on the authority granted by the freedom of choice waiver approved by the Centers for Medicare and Medicaid Services (CMS) effective March 17, 1995. The second phase is Medi-Cal Specialty Mental Health Services Consolidation, based on the renewal, modification and renaming of the Medi-Cal Psychiatric Inpatient Hospital Services Consolidation waiver, which was approved by CMS on September 5, 1997. The current request for waiver renewal would continue the existing program as it was originally designed by the State and approved by CMS, but with changes to incorporate the new Medicaid managed care regulations by August 13, 2003, from November 20, 2002 to November 19, 2004. The final planned step would be the transfer of risk for federal financial participation (FFP) through capitation or other risk arrangement, to be phased in at a later date.

C. Background

In 1957, California passed legislation creating the Short-Doyle Program, which required counties to ensure delivery of mental health services to a target population through a system of directly operated and contract providers.

Congress passed two major amendments to the Social Security Act (the Act) in July 1965 that expanded the scope of health benefits to persons eligible for federal grants: Title XVIII, the Medicare legislation for persons 65 years of age and over, and Title XIX, the Medicaid legislation that provided federal matching funds to states that implemented a comprehensive health care system for the poor under the administration of a single state agency.

In 1966, legislation was passed establishing the California Medical Assistance Program (Medi-Cal), based on the provisions of Title XIX, for medical services to eligible federal cash grant welfare recipients. The specialty mental health services reimbursed by this program included psychiatric inpatient hospital services, nursing facility care, and professional services provided by psychiatrists and psychologists.

In 1971, legislation in California added Short-Doyle community mental health services into the scope of benefits of the Medi-Cal program for the first time. This change enabled counties to obtain federal matching funds for their costs of providing Short-Doyle community mental health services to persons eligible for Medi-Cal. At this point the Medi-Cal program was split into two mental health delivery systems. The original program continued as the Fee-for-Service/Medi-Cal (FFS/MC) system; the counties became the providers of a new benefit, Short-Doyle/Medi-Cal (SD/MC) services. SD/MC services included many of the services provided by the Short-Doyle program, but not all. Socialization and vocational programs, for instance, were not covered. The SD/MC program provided a much broader range of mental health services, using a wider group of service delivery personnel, than were offered under FFS/MC.

A Medicaid State Plan Amendment implemented in October 1989 added targeted case management to the scope of benefits offered under the SD/MC system. Another State Plan Amendment, implemented in July 1993, added services available under the Rehabilitation Option to the SD/MC scope of benefits and broadened the range of personnel who could provide services and the locations at which services could be delivered.

Based on approval of a Section 1915(b) waiver effective March 17, 1995, California consolidated FFS/MC and SD/MC psychiatric inpatient hospital services at the county level. County mental health departments became responsible for both FFS/MC and SD/MC psychiatric inpatient hospital systems for the first time. CMS approved State Plan Amendment 95-016, which described the reimbursement methodology used for psychiatric inpatient hospital services under

the consolidated program. A separate Section 1915(b) waiver was also approved for the Medi-Cal Mental Health Care Field Test in San Mateo County in 1995.

In 1997, California requested a renewal, modification and renaming of the Medi-Cal Psychiatric Inpatient Hospital Service Consolidation waiver program to include both inpatient hospital and professional specialty mental health services under the responsibility of a single mental health plan (MHP) in each county. The renewed waiver, called Medi-Cal Specialty Mental Health Services Consolidation, was approved by CMS on September 5, 1997.

Implementation of the renewed waiver, referred to as “Phase II" implementation, occurred at various times in each California county between November 1, 1997, and July 1, 1998, depending on the readiness of the MHP in each county. During the first waiver renewal period, MHPs became responsible for authorization and payment of professional specialty mental health services that were previously reimbursed through the FFS/MC claiming system. At that time, both inpatient hospital and professional Medi-Cal specialty mental health services previously reimbursed through FFS/MC and SD/MC claiming systems became the responsibility of a single entity, the MHP, in each county.

D. Current Programs

1. Mental Health Plans

As of 1995, authorization of psychiatric inpatient hospital services became the responsibility of an MHP in each county. Between November 1997 and July 1998, MHPs also became responsible for outpatient and inpatient professional specialty mental health services. Under the current waiver, which expires November 19, 2002, all MHPs are county mental health departments, although if a county elects not to participate in the program, another entity may be the MHP. MHPs are at risk for the state matching funds for services provided to Medi-Cal beneficiaries and claim FFP on a cost or negotiated rate basis.

2. Geographic Managed Care (Sacramento County)

In Sacramento County, physical health care services to Medi-Cal beneficiaries are provided through the Geographic Managed Care (GMC) program. Enrollment in the program is mandatory for beneficiaries whose Medi-Cal eligibility is based on eligibility for Temporary Assistance to Needy Families (TANF) or related programs and optional for beneficiaries who qualify for Medi-Cal based on other aid categories. GMC enrollees may choose from several health care service plans. At the request of the Sacramento County MHP, two of the GMC plans continue to cover some or all specialty mental health services through their GMC contracts with the State Department of Health Services (DHS), rather than under the Medi-Cal Specialty Mental Health

Services Consolidation waiver program. Kaiser Permanente provides psychiatric inpatient hospital services and professional specialty mental health services for its Sacramento GMC members. Western Health Advantage continues to cover outpatient professional specialty mental health services, but not psychiatric inpatient hospital services. Please note that this arrangement applies only to the two identified health plans in the GMC program in Sacramento County, and does not apply to the GMC program in San Diego.

3. Field Tests

In addition to the Medi-Cal Specialty Mental Health Services Consolidation waiver program, there are two separate managed mental health care field test programs operating in California counties. These two programs are intended to test managed care concepts for possible application to the statewide Medi-Cal managed mental health care program as the State progresses toward full implementation. These programs are described below.

San Mateo

Effective April 1, 1995, all Medi-Cal specialty mental health services, including psychiatric inpatient hospital services, were fully consolidated under the county mental health department. San Mateo County developed an MHP through a participatory local public planning process.

Some of the changes needed to implement this pilot required a federal waiver. A request under Section 1915(b) of the Act for waivers of statewideness, comparability of services and freedom of choice was submitted in May 1994 and granted in February 1995. These waivers have been renewed through July 29, 2003. The MHP is responsible for all medically necessary specialty mental health services to Medi-Cal beneficiaries in San Mateo County. Services are delivered by a combination of county community-based agencies and traditional providers based on a system of care model.

During the initial waiver period, FFP was obtained through fee-for-service billing under the SD/MC system and an annual cost reconciliation, which is essentially the same process used under the Medi-Cal Specialty Mental Health Services Consolidation waiver. During the second and current renewal period of the San Mateo waiver, FFP for most services is claimed based on a six-level case rate, with three levels of payment for children and three levels for adults. The six levels are based on the level of care clients require to treat their mental health condition appropriately. Under the second waiver renewal period and the current renewal period, the San Mateo County MHP also assumed responsibility for authorization of pharmacy and related laboratory services when prescribed by a psychiatrist for a mental health condition.

The San Mateo field test has provided valuable information on: 1) access for beneficiaries through a centrally administered access system; 2) the definition of medical necessity; 3) a public/private network service delivery system; 4) innovative contracting arrangements, including shared risk contracting; 5) a program to ensure adequate interface with the primary care system; 6) management information needs; and 7) performance outcomes and client satisfaction. Under the waiver renewal which continues the field test through July 29, 2003, San Mateo County is continuing to field test federal reimbursement based on case rates and authorization of pharmacy and related laboratory services, as described in the previous paragraph. The data gathered from this field test will be instrumental in providing the State with information necessary to evaluate the feasibility of moving toward a capitation phase of the Medi-Cal managed mental health care program.

Solano

In May 1994, DHS established a new county organized health system (COHS) to provide Medi-Cal services (with the exclusion of SD/MC services) for all beneficiaries in Solano County. Upon implementation, Solano County Mental Health became a subcontractor on a capitated basis to the COHS for all specialty mental health services that were previously provided under FFS/MC. The contract with the COHS places the SD/MC and FFS/MC specialty mental health systems under a single management. The funds, however, are not consolidated and are accounted for separately, since they are still two separate and distinct funding systems. Solano County Mental Health was required to set up a clear audit trail to ensure that capitated funds from the COHS were not being used to match federal funds for SD/MC services. Solano County Mental Health retained the responsibility for SD/MC services, which are reimbursed on a fee-for-service basis, and assumes the responsibility for FFS/MC specialty mental health services by establishing separate provider networks and authorization and payment systems in order to maintain a clear audit trail. The State expects that administration of the FFS/MC and SD/MC funding streams will be integrated when both are fully capitated. Solano County Mental Health, using capitated dollars from the COHS, has contracted with those private providers who previously provided services under FFS/MC.

The primary issues of the Solano County Mental Health field test included determining management information systems needs, medical necessity standards, techniques for managing the scope of benefits, and systems of care design in a managed care environment. Solano County Mental Health has provided training to other county mental health departments and other interested parties regarding its experience with capitation and this field test.

Using a competitive bidding process, Solano County Mental Health developed a contract with U.S. Behavioral Health (now United Behavioral Health), a private managed care company, to assist with the implementation and management of the capitated services. This public/private partnership has already produced some helpful information for other counties to consider as they make the transition to capitation with respect to strengths and limitations of private behavioral health firms, in areas such as provider relations, information systems and utilization management. Solano County Mental Health also contracts with Kaiser Permanente on a capitated basis to provide mental health services (excluding SD/MC services) for Medi-Cal beneficiaries who select Kaiser for their physical health care.

The State has continued the Solano County field test because it has proved an effective model for the county. When the COHS was expanded to include Napa and Yolo County beneficiaries, the State gave Napa and Yolo County Mental Health Departments the opportunity to operate under the same arrangement as Solano County. Both departments elected to participate in the Medi-Cal Specialty Mental Health Consolidation waiver program.

E. Program Under the Proposed Third Waiver Renewal Period

The program proposed by this third waiver renewal request is generally the same as under the current waiver renewal approved effective November 20, 2000. There will be program changes effective August 13, 2003 to incorporate the requirements of the new Medicaid managed care regulations that were released June 14, 2002. The State will be requesting waivers of some of these regulations to allow the waiver program to continue to provide services through a single MHP in each county and to retain features of the current waiver design that provide for equal or better access, quality of care and cost-effectiveness.

II. General Description of the Waiver Program

A. The State of California requests to renew its waiver for Medi-Cal Specialty Mental Health Services Consolidation under the authority of Section 1915(b) of the Act.

DHS is the single state agency for Medicaid with the overall responsibility for administering the Medi-Cal Program. The waiver program will be operated by the Department of Mental Health (DMH), through an interagency agreement with the single state agency. DMH then contracts with an MHP in each county that will directly provide or subcontract for the provision of services. DMH is responsible for monitoring and oversight activities to ensure that the services provided comply with all federal and state requirements. DMH requires MHPs to establish and utilize systems to review the quality and appropriateness of specialty mental health services funded by Medi-Cal and audits for compliance with Medi-Cal requirements. These and additional duties of DHS and DMH are covered in the interagency agreement between the two departments. DHS retains ultimate responsibility for the waiver program by establishing basic program policies, overseeing DMH in its performance under the interagency agreement, and reviewing MHPs directly as appropriate. The interagency agreement for the third renewal period is currently in process and should be fully executed by the end of August 2002. A copy of the agreement is provided in **EXHIBIT 1.**

B. Effective Dates: This waiver renewal is requested for a period of two years effective November 20, 2002 and ending November 19, 2004.

C. The waiver program will continue to be called Medi-Cal Specialty Mental Health Services Consolidation.

D. Geographical Areas of the Waiver Program

The waiver will be implemented statewide, with the exception of San Mateo and Solano Counties. Cost effectiveness as shown in Section V.C. of this waiver renewal request includes the entire state except for the San Mateo County and the Solano County Field Tests. The San Mateo County Field Test is operated under a separate waiver program under Section 1915(b) of the Act, titled the Medi-Cal Mental Health Care Field Test (San Mateo County). The Solano County Field Test is being operated under a separate Section 1915(b) waiver for the Partnership Healthplan of California, a COHS. Geographic areas of the waiver program for this renewal period will be the same as the currently operating waiver program.

E. State Contact: The State contact persons for this waiver are Richard Hildebrand, Health Program Specialist, Freedom of Choice Waiver Unit Rate Development Branch, at DHS, who can be reached at (916) 657-0533 and Rita McCabe-Hax, Chief, Managed Care Implementation, at DMH, who can be reached at (916) 651-9370.

F. Statutory Authority

The State's waiver program is authorized under Section 1915(b)(4) of the Act. The State requires beneficiaries to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provisions of covered care and services. These providers are county MHPs, which are prepaid health plans as defined in current federal regulations. As of August 13, 2003, under the new Medicaid managed care regulations, the MHPs may be prepaid inpatient health plans (PIHPs). Please note that the State is not requesting waiver authority under Section 1915(b)(1) of the Act. The waiver program is not a specialty physician services arrangement; services in the program may be provided under the direction of physician or other licensed mental health professionals. Depending on the needs of individual beneficiaries, these mental health professionals may or may not act as a gatekeeper to other specialty mental health services.

G. Other Statutory Authority

The State is relying on a continuation of the exemption from federal competitive procurement and sole source requirements granted by CMS for the initial waiver and renewed in the CMS waiver approval letter of November 19, 2000. The State assures CMS that the justification for the sole source exemption continues to exist as described in the State's initial request for exemption submitted October 11, 1996 and the second request submitted in the response for additional information request by CMS as part of the review of the waiver renewal request for the second waiver renewal period. The request has been updated for the current waiver renewal request and has been included as **EXHIBIT 2**.

If a county terminates its MHP contract or if the State terminates a county's MHP contract for cause, the State intends first to look for another county willing to serve as the MHP. If no other county is interested, the State will conduct a competitive procurement process to select a new MHP. Currently all 54 MHPs in the 56 covered counties are county mental health departments, including one county mental health department (Placer) that is serving as the MHP for neighboring Sierra County and one MHP operating under a joint powers agreement between Sutter and Yuba Counties to serve Medi-Cal beneficiaries in both counties.

H. Waivers Requested

Relying on the authority of the above Section, the State requests a waiver of the following subsections of Section 1902 of the Act, to the extent they are required.

1. Section 1902(a)(1) of the Act—Statewideness: This section of the Act requires a Medicaid State Plan to be in effect in all political subdivisions of the State. This waiver program is not available in San Mateo and Solano Counties. Beneficiaries in San Mateo County receive psychiatric inpatient hospital services and other specialty mental health services under a separate Section 1915(b) waiver, entitled Medi-Cal Mental Health Care Field Test (San Mateo County). In Solano County, the county mental health department is a subcontractor of the Partnership Healthplan of California, which also operates under a separate waiver. In Sacramento County, beneficiaries who are members of the Kaiser Permanente and Western Health Advantage health care service plans, contracted through the GMC program, will receive some or all of their specialty mental health services through that program, also operating under a separate waiver.

2. Section 1902(a)(4) of the Act—Methods of Administration: This section of the Act allows the Secretary, Department of Health and Human Services, to establish regulations governing the administration of the Medicaid program. Under this authority, CMS adopted regulations applicable to Medicaid managed care programs at Title 42, Code of Federal Regulations (CFR), Part 400, et al., which were published in the Federal Register on June 14, 2002, and must be implemented August 13, 2003, during the waiver renewal period. Based on California's initial review of the regulations, MHPs appear to be Prepaid Inpatient Health Plans (PIHPs), making the State and the MHP subject to the new regulations that apply to PIHP programs. Since Section 1902(a)(4) of the Act is waivable under a Section 1915(b) waiver program, the State requests a waiver of the following regulations to allow the State to maintain key features of the Medi-Cal Specialty Mental Health Services Consolidation waiver program as it was originally designed by the State and approved by CMS, while adopting core features of the new regulations, consistent with access, quality, and efficient and economic provision of covered care and services.

   The State has reviewed the new regulations as carefully as possible to determine the critical waivers needed to continue to operate the Medi-Cal Specialty Mental Health Services Consolidation waiver program consistent with its original design. The required submission date for the waiver renewal request, the time required to prepare the request, and state budget-related travel limitations have not allowed the State to take full advantage of the training offered by CMS on the new regulations. The State asks that CMS consider our requests for waivers in this light and provide opportunities during the waiver review process to discuss the issues raised here.

a) Section 438.2—Definitions: This section provides definitions of terms used throughout Part 438. The definition of health care professional does not include Marriage and Family Therapists (MFTs) or psychiatric technicians (PTs). Both are licensed practitioners of the healing arts under California law. The scope of practice for MFT includes the delivery of psychotherapy and the ability to diagnose mental illness. PTs have a narrower scope of practice, but perform essential functions in the treatment of mental illness. CMS indicated in response to comments of the regulations that CMS did not have the authority to expand the definition of health care professional beyond the definition in the Balanced Budget Act of 1997 relevant to the prohibition against managed care limits on the treatment options professionals can present to their patients. It does not appear that this limit extends to State decisions to expand the definition. To the extent necessary, the State requests a waiver of the definition of health care professional to add MFTs and PTs. This waiver will allow the State to continue to use MFTs and PTs to perform authorization, second opinion, grievance and appeal functions appropriate to their scope of practice and experience. This waiver will prevent a reduction in access under the waiver and allow continued cost-effective use of licensed mental health professionals in the waiver program.

b) Section 438.6—Contract requirements: This section establishes general requirements for PIHP contracts. Subsection (c)(5) assumes that contract provisions will cover risk-sharing arrangements with MHPs. The State has established a small county risk pool for MHPs in counties with populations of 200,000 or less by statute rather than contract. A waiver is requested to continue this practice. A fiscal study by Newpoint Group, Inc. determined that the optimum balance for the pool was about $3,000,000. The pool consists of an annual payment of State General Funds (SGFs) only (no FFP) of up to $750,000, depending on the amount required to keep the balance in the pool as close as possible to the $3,000,000 level. When the funds are used to provide services, FFP would be claimed for the actual services. It is impractical to establish a separate pool for each MHP, given the very small numbers of clients served by these MHPs. There is no impact on quality of care or cost-effectiveness related to this waiver request; the ability to share the pool among MHPs likely to have larger year-to-year changes in costs may improve access.

c) Section 438.10—Information requirements: This section establishes specific requirements for the types, content, and distribution of information describing the PIHP program. Waivers are requested of Subsections (e) and (f) to allow the State to require MHPs to provide basic informing materials to Medi-Cal beneficiaries upon request and when they first access specialty mental health services from the MHP. The MHPs would be required to provide supplemental information, e.g., information on significant changes as described

in subsection (f)(4), to all beneficiaries receiving specialty mental health services from the MHP.

All Medi-Cal beneficiaries are automatically enrolled in the waiver program when they become Medi-Cal eligible, not through a formal enrollment process, but by virtue of the county of responsibility established as a routine component of the eligibility process. The county of responsibility code on the Medi-Cal Eligibility Data System (MEDS) also serves to identify the county MHP responsible for specialty mental health services for the beneficiary. There are, therefore, no potential enrollees. About 5 to 15 percent of beneficiaries will use specialty mental health services, based on State utilization data and general prevalence data.

Establishing a separate enrollment process only for beneficiaries who are in need of specialty mental health services would increase administrative costs and could result in delays in receiving care. The State will issue annual notices regarding the information available from the MHPs to all Medi-Cal households, so all beneficiaries will receive information about the program on a regular basis. This waiver is cost-effective. Both the State and the federal government would participate in the increased cost of a separate enrollment system. Both the MHPs and the federal government would participate in the increased cost of providing informing materials to all beneficiaries. The current system eliminates some potential barriers to access that are likely if a separate enrollment system were established for beneficiaries in need of specialty mental health services. There is no impact on quality of care.

There are references to these informing requirements through out the regulations. To the extent necessary, waivers are requested of all sections that mention a PIHP's obligation to inform all enrollees to allow informing of all beneficiaries on request and beneficiaries who are accessing services, consistent with the conditions described in this waiver of Section 438.10.

d) Sections 438.52 and 438.56—Enrollment and disenrollment: These sections establish enrollment and disenrollment standards for managed care programs where beneficiaries have a choice of PIHPs. The basic design of the Medi-Cal Specialty Mental Health Services Consolidation waiver program provides for mandatory and automatic enrollment of all Medi-Cal beneficiaries in the single MHP in each of the counties included in the program. The program design does not include an option for disenrollment, either by the MHP or the beneficiary. This design element is the reason the State has operated the program through a Section 1915(b)(4) waiver of beneficiary freedom of choice, Section 1902(a)(23), as described in item 4 below. Therefore, the State requests waiver of Sections 438.52 and 438.56. These waivers will provide access, quality of care and cost-effectiveness that are at least equal to access, quality of care and cost-effectiveness without these

waivers. See **EXHIBIT 2,** which justifies the related sole source exemption requested for this program. The State has established county mental health departments, the core providers in California's public mental health system, as the MHPs in this program. The experience and commitment of county mental health departments in addressing the needs of individuals with mental illness more than offset possible gains from competition.

There are references to enrollment and disenrollment requirements through out the regulations. To the extent necessary, waivers are requested of all sections that establish requirements related to enrollments and disenrollments, consistent with the conditions described in this waiver of Section 438.52 and Section 438.56.

e) Section 438.114—Emergency and post stabilization services: The definition of an emergency medical condition in this section provides no clear operational definition of a mental health emergency. In its response to comments on this section, CMS acknowledges that no specific guidance is provided on defining emergency psychiatric conditions, but mentions that emergency psychiatric conditions are included as conditions "placing the health of the individual . . . in serious jeopardy." We agree, but also believe it is critical to provide an operational definition of emergency psychiatric conditions to the MHPs, providers and beneficiaries. The State operationalized its own definition of emergency medical conditions as part of the original waiver request. We propose to continue the definition of emergency psychiatric conditions and urgent conditions and the related access requirements placed on the MHP that were already established for the waiver program. Please refer to **APPENDIX III-B-3** and **EXHIBIT 4**, Title 9, California Code of Regulations (CCR), Section 1810.216, for our proposed definition of an emergency psychiatric condition. We believe these standards are consistent with the intent of Section 438.114, but to the extent there are technical differences between the two, we request a waiver of proposed Section 438.114.

   There are references to emergency medical conditions in other locations in these regulations, e.g., Section 438.10(f)(6)(viii)(A). To the extent necessary, waivers are requested of all sections that establish requirements related to emergency medical conditions, consistent with the conditions described in this waiver of Section 438.114.

f) Sections 438.400—Definitions related to grievances, appeals, notices of action and the continuation of benefits pending appeals and fair hearings: Section 438.400(b) defines "action" requiring a notice of action and subject to appeals and fair hearings to include situations in which the MHP denies payment to the provider after the service has already been delivered to the beneficiary. The State believes this is a necessary requirement in states that allow providers to bill enrollees for services when payment is denied by the PIHP, but is

unnecessary in California. California law (Welfare and Institutions Code Section 14019.4) prohibits providers from recovering denied payments from enrollees. A waiver of this section is requested to exclude a denial, in whole or in part, of payment for a service after the service has already been delivered to the beneficiary. This waiver will not reduce beneficiary access to care, since the beneficiary will not have been denied any service, nor will the beneficiary be responsible to pay for the services already delivered. There will be no impact on quality of care or cost-effectiveness.

California requires MHPs to provide notices of action and opportunities for appeal and fair hearing when the MHP or its providers determine that a beneficiary does not meet the medical necessity criteria in Title 9, CCR, Section 1830.205(b)(1), (b)(2), or (b)(3)(C) and as a result is not entitled to any services from the MHP (see **EXHIBIT 4**). In its September 5, 1997 waiver approval letter, CMS required that the State include these notices of action and fair hearing rights when the MHP determines that the beneficiaries' mental illness should be treated by a primary care provider as a condition of waiver approval. Although in most cases this will involve the denial of request for services from a beneficiary, there may be instances where the beneficiary requests an assessment, which would be delivered, but would not request an additional service from the MHP, because of lack of understanding that the MHP or provider's decision to refer the beneficiary outside the MHP could be challenged. To the extent necessary for the State to continue to require that MHPs issue notices of action in these situations and to continue to provide access to the MHP appeal process and the fair hearing process on these issues, the State requests a waiver of Section 438.400(b) to include these situations in the definition of "action."

Section 438.400(b) defines "appeal" to include only those issues that meet the definition of "action" in the same subsection. In response to public comments, CMS changed the definition of action to cover only actions by MCOs and PIHPs, not actions by providers. CMS also stated its clear intent that a denial of an enrollee's request for services by a provider could be raised to the MCO or PIHP, at which point a denial would be an action. CMS, however, did not provide a clear mechanism to facilitate the review. The State proposes to expand the issues covered by the appeal process to cover such denials, even though a notice of action would not have been provided to the beneficiary. The State also proposes to allow these issues to be raised in fair hearing. A waiver of this section is requested to expand the issues subject to appeal. A related waiver of Section 431.200(b) is requested to expand the issues subject to fair hearing. There would be no negative impact on access, quality of care or cost-effectiveness related to these waivers.

g) Section 438.420—Continuation of benefits while the MCO or PIHP appeal and

the State fair hearing are pending: Section 438.420(b) limits aid paid pending an appeal or fair hearing to situations in which a course of treatment previously authorized by the provider or the PHP is terminated or reduced. This provision means that, if a course of treatment is authorized by the PIHP for six months and, at the end of the six months, the provider requests continuation of the services, the provider's request will be treated as a new request. The enrollee would not receive services pending the fair hearing process. California provides aid paid pending a state fair hearing in these cases in the FFS/MC program under the State plan and in its managed care waiver programs as a result of a lawsuit settlement (Frank v. Kizer). California believes the same standard that applies to California Medi-Cal beneficiaries under the State plan should apply to beneficiaries in its managed care programs. Section 438.420(d) provides that the MCO or PIHP may recover the costs of benefits pending an appeal or fair hearing if the beneficiary loses the appeal or fair hearing. The section appears to leave the recovery to the discretion of the MCO or PIHP. California's FFS/MC program reimburses providers for services provided pending fair hearings and does not recover funds from beneficiaries if they lose. These provisions have been extended to beneficiaries under the Medi-Cal Specialty Mental Health Services Consolidation waiver program.

The State proposes to provide aid paid pending fair hearings in accordance with current state regulations at Title 9, CCR, Sections 1850.215 (see **EXHIBIT 4**). A key section of the general Medi-Cal regulations is cross-referenced in this section. This regulation is provided at **APPENDIX II-H-2**. The State's regulations provide benefits to enrollees beyond those included in the federal regulations (expanded aid paid pending and protection from billing by providers and MHPs if provider payment is denied or a fair hearing involving aid paid pending is denied). A waiver of Section 438.420 is requested to continue these practices. This waiver will have no negative impact on access or quality. The waiver will also be neutral with respect to costs because the costs of these services are covered under the State plan.

3. Section 1902(a)(10)(B) of the Act—Comparability of Services: This section of the Act requires that all services for categorically needy individuals to be equal in amount, duration, and scope. The State requests waiver of this section based on the facts below.

   Although this waiver program includes essentially the same services as those available outside the waiver program, the services are provided in a somewhat different array than those provided outside the waiver program. In the non-waivered Medi-Cal program, psychologist services are included in a group of optional Medicaid services that are limited to two total services per month. Direct services provided by licensed clinical social workers (LCSWs); MFTs; and

registered nurses (RNs) are available only to children eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, not to adults. Mental health-related targeted case management services are available only to limited populations specifically described in the State Plan and only from SD/MC providers. Rehabilitative mental health services are also available only from SD/MC providers.

Under the waiver program, targeted case management services and services of psychologists, LCSWs, MFTs and RNs are available to all beneficiaries based on medical necessity, rather than limits on specific populations or numbers of services. Rehabilitative mental health services under the State Plan, however, have always included the direct services of psychologists, LCSWs, MFTs and RNs without respect to the age of the beneficiary or the number of services per month. Targeted case management services under the waiver are available to all beneficiaries who meet medical necessity criteria, rather than population criteria; however, the State does not expect this change in criteria to have a measurable effect on the beneficiaries eligible for the services. The beneficiaries for whom targeted case management would be a therapeutic intervention under the waiver program's medical necessity criteria are expected to be the same beneficiaries who met the target population criteria under the State Plan.

Also, Kaiser Permanente and Western Health Advantage, two health plans contracting with DHS in the Sacramento GMC program, will continue to cover some specialty mental health services under their contracts with DHS for their enrolled beneficiaries, rather than the enrolled beneficiaries receiving these services through the Sacramento MHP under the Medi-Cal Specialty Mental Health Services Consolidation waiver program. Kaiser Permanente will cover psychiatric inpatient hospital services provided in FFS/MC hospitals and inpatient and outpatient professional specialty mental health services for its enrollees. Western Health Advantage will cover outpatient professional specialty mental health services for its enrollees. For Kaiser Permanente enrollees, the Sacramento MHP will cover psychiatric inpatient hospital services in SD/MC hospitals, rehabilitative mental health services, and targeted case management. The Sacramento MHP will cover all psychiatric inpatient hospital services for Western Health Advantage enrollees as well as psychiatric inpatient hospital professional services, rehabilitative mental health services, and targeted case management services.

As described in the previous waiver renewals, enrollees in several small special projects administered by DHS will continue to receive most Medi-Cal specialty mental health services through the contracts between DHS and the special projects. The special projects involved are the State's projects under the Program for All-Inclusive Care for the Elderly (PACE); the Senior Care Action Network (SCAN), a social health maintenance organization operating under an 1115 waiver; and the Family Mosaic Project; which operates under separate 1915(a) waiver.

Enrollees in these programs may receive rehabilitative mental health services under the Medi-Cal Specialty Mental Health Services Consolidation waiver program. In the last waiver renewal request, the Acquired Immune Deficiency Syndrome (AIDS) pilot project, which had less than 800 members at the time, also covered outpatient specialty mental health services for its members. The AIDS pilot project contract was amended effective April 2002 to exclude these services. At the time of transition, DHS indicated that none of the members were receiving specialty mental health services from the project, so there were no transition problems.

4. Section 1902(a)(23) of the Act—Freedom of Choice: This section of the Act requires a Medicaid State Plan to permit all individuals eligible for Medi-Cal to obtain medical assistance from any qualified provider in the State. Under this waiver program, the free choice of providers will be restricted. That is, individuals in this program are constrained to receive non-emergency psychiatric inpatient hospital services and other specialty mental health services from the MHP or from providers that have contracted with the MHP of the beneficiary.

I. Enrollment Figures

Number of enrollees for under the Medi-Cal Specialty Mental Health Services Consolidation waiver program by state fiscal year (FY):

FY 1997-98: 5,199,371
FY 1998-99: 5,197,737
FY 1999-00: 5,252,008
FY 2000-01: 5,570,683
FY 2001-02: 5,979,115

Projected number of enrollees for third waiver renewal period, November 20, 2002, through November 19, 2004:

FY 2002-03: 6,143,962
FY 2003-04: 6,314,681
FY 2004-05: 6,491,493

J. Waiver Populations

All Medi-Cal beneficiaries will be included in the State's waiver program. Limited scope beneficiaries will be covered only to the extent that the services within their scope of benefits are included as services under the waiver.

K. Enrollment Requirement

Beneficiary enrollment in the program is mandatory. All Medi-Cal beneficiaries will receive medically necessary non-emergency specialty mental health services included under the waiver through the MHP, from providers employed by the MHP, contracted with the MHP, or other providers authorized by the MHP.

L. Excluded Populations

Beneficiaries are excluded from participation in the waiver if they:

1. Are enrolled in a Medi-Cal managed care plan that covers specialty mental health services included under the waiver but only for the services covered by the Medi-Cal managed care plan (Sacramento County beneficiaries who are enrolled in Kaiser Permanente or Western Health Advantage; beneficiaries enrolled in PACE programs, SCAN, or Family Mosaic); or,

2. Live in an area excluded from the waiver (San Mateo and Solano Counties).

M. Access Standards

Access under the current and renewed waiver program is assured through State regulations (for examples, see **EXHIBIT 4**, Title 9, CCR, Sections 1810.310, 1810.345, 1810.405, 1830.220, and 1830.225); through the State's review and approval of any amendments to the MHPs' implementation plans for the program; through on-going contract management by DMH; and through formal annual reviews of the MHPs by the DMH Program Compliance Division. During the current waiver period the State conducted reviews of the MHPs that consisted of meetings with MHP and DMH staff and chart reviews of SD/MC inpatient hospitals and outpatient programs. The methodology for selecting the charts to be review is included as **APPENDIX II-M-1**. One section of the review protocol focuses exclusively on access (see **EXHIBIT 6** for the current protocol). DMH Program Compliance Division plans to continue the reviews during the third waiver period. **APPENDIX II-M-2** includes the review schedule for FY 2002-03.

The Program Compliance Division reviews have generally found that MHPs provide access to specialty mental health services that is equivalent or better than access prior to the waiver. Requests for services to treat urgent psychiatric conditions are acted on within one hour of the request. Medi-Cal beneficiaries with emergency psychiatric conditions receive immediate access to psychiatric inpatient hospital services. For routine service under the waiver, Medi-Cal beneficiaries are able to rely on MHP provider networks for timely service

referrals, so the beneficiaries are not required to find a specialty mental health provider willing to accept Medi-Cal on their own. Additionally, under the waiver, more beneficiaries are able to receive services from a wider variety of providers than in the Medi-Cal program prior to the waiver, including services from LCSWs, MFTs, and RNs with Masters' Degrees in psychiatric nursing and from community-based mental health agencies.

Please refer to Section III.C.1 below for a description of provider participation currently in place and proposed for the renewal period.

N. Additional Information Requested by CMS.

In its approval letter November 16, 2000, CMS requested that the State provide an assessment of the sources of state funding for which federal match is requested as a part of this waiver renewal request. The assessment was to include funding amounts and sources, including all use of governmental transfers, certified public expenditures and other designated State funding revenue sources.

The assessment required by CMS involved a review of the same data used by the State in preparing a report to the Legislature evaluating mental health funding since inception of realignment. Realignment refers to the State funding of county health, social service and mental programs through sales and motor vehicle tax revenues established in 1991. The data below and provided in **APPENDIX II-N** was developed for the study, except that the analysis here covers only counties under the waiver, rather than all counties.

State Matching Funds for Medi-Cal

Medi-Cal is a jointly funded state and federal program. The federal medical assistance percentage (FMAP) represents the percentage of services paid for by FFP. The FMAP varies depending on the type of cost and on a formula based upon the relationship of the per capita income of the State to the per capita income of the United States. It has fluctuated between 50 percent and 52 percent during this time period.[1] In California, DHS is the designated single state Medi-Cal agency. DHS is responsible for ensuring that the State provides the matching state funds for the federal Medi-Cal funds. Realignment replaced the state funds that were previously used as Medi-Cal match with sales tax and vehicle license fees. Counties now contract with the DMH to serve as MHPs under the waiver and assume all responsibility for the state match for Medi-Cal services, except for EPSDT services.

[1] The calculation is based on the federal fiscal year (Oct. - Sept) and has fluctuated between 50% and 52% beginning in 1996-97. Prior to that it was 50%. Exact percentages are--Federal FY 96-97 50.23%, 97-98 51.23%, 98-99 51.55%, 99-00 51.67%.

Implementation of the Rehabilitation Option in 1993 allowed counties to increase FFP revenues significantly. Three additional changes to the Medi-Cal program have occurred since inception of realignment in FY 1991-92 that have resulted in counties receiving additional SGFs which are used as Medi-Cal match. These changes are the Medi-Cal specialty mental health services consolidation discussed earlier, the initial expansion of EPSDT services, and the additional expansion created by the addition of therapeutic behavioral services (TBS) as a new EPSDT benefit.

Under Medi-Cal Specialty Mental Health Services Consolidation, SGFs are appropriated each year to DMH based upon the estimated amount DHS would have incurred for psychiatric inpatient hospital services and psychiatrist and psychologist services absent the waiver program. In general, each MHP receives, at a minimum, SGFs equal to the amount spent in their county prior to the waiver program. The majority of future growth in these services due to changes in Medi-Cal beneficiaries and/or cost of living is allocated to MHPs based on weighted relative need, which reflects the percentage of total need a MHP requires to equal to the statewide weighted average cost per Medi-Cal beneficiary in FY 1993-94, weighted by Medi-Cal aid code group (note that relative need in FY 1995-96, the first year under the waiver program, was calculated separately for each aid code group and was not weighted). Weighted relative need has not been recalculated since the waiver program began, and MHPs with an above weighted average cost per Medi-Cal beneficiary in
FY 1993-94 have not received a growth increase in their SGF allocation since FY 1995-96, although all MHPs have received increases in their overall allocations due to the inclusion of FFS/MC professional services under the waiver in 1997, FFS/MC provider rate increases and other minor program changes). This SGF allocation is used as Medi-Cal match by MHPs prior to using realignment funds.

A 1994 California lawsuit expanded Medi-Cal services to Medi-Cal beneficiaries under 21 years of age who need medical assistance to correct or ameliorate illnesses or conditions to include all optional services, whether or not such services were covered under the Medicaid State Plan. As a result of the expanded interpretation of EPSDT requirements, DHS decided to provide SGFs as the match for rehabilitative mental health services and targeted case management provided to EPSDT-eligible beneficiaries through the SD/MC program to ensure adequate access to these services. DHS developed an interagency agreement with DMH through which MHPs are reimbursed the entire non-federal share of cost for all EPSDT-eligible services in excess of the expenditures made by each MHP for these services during FY 1994-95. When FFS/MC professional services were added under the waiver in 1997, the baseline also increased by the proportion of that allocation that had historically been used for that population.

Another lawsuit, filed in 1998, recently resulted in the approval of TBS as a new

EPSDT supplemental specialty mental health service for the Medi-Cal program. Since these services were not included in the original realigned services, new SGFs are provided to MHPs as match for these services.

Table S1, in **APPENDIX II-N**, shows the FFP and required match for each county for Medi-Cal mental health services provided by MHPs for FY 1990-91, FY 1993-94, FY 1996-97, and FY 1999-00. FFP in FY 1996-97 and FY 1999-00 include both the SD/MC program and inpatient consolidation. Table S1 also shows the SGF allocations for the waiver program (managed care) and funding for EPSDT and TBS. FY 1999-00 funding for EPSDT and TBS was estimated based upon the most recently available cost report and claims information. Although cost-settled data are now available for FY 1999-00, they were not available at the time Table S1 was prepared. There would be some differences in dollars shown as a result, but the basic principles of the analysis would remain the same. Finally, Table S1 shows the amount of realignment used as match for FFP, the percent this reflects of total realignment funding, the amount of remaining realignment, and total realignment allocations.

Statewide, the percent of realignment funds required as Medi-Cal match has increased slightly since prior to realignment in FY 1990-91, from 17 percent to about 24 percent. However, there are significant differences among the counties (shown in Table S1, **APPENDIX II-N**), with quite a few counties having to use a higher percent of realignment every year to cover Medi-Cal match requirements. These differences are due to several factors—the amount of each county's original managed care allocation, how much Medi-Cal growth they receive each year, and how much of their Medi-Cal growth has been in EPSDT and TBS, which are both matched by SGF, rather than realignment dollars.

Table S2, below, provides a rough estimate of the statewide match required under the current two-year waiver period and the two-year waiver renewal period. The figures in Table S2 assume the FMAP is constant and that both managed care and realignment allocations do not increase from FY 2000-01 amounts during the waiver period. Even with these very conservative assumptions, there is an estimated $600 million in annual realignment funding over and above what is required to match the federal funds.

Table S2
Estimated Match Required Under the Waiver

	Year Under Current Waiver		Year Under Waiver Renewal	
	Year 1	Year 2	Year 1	Year 2
Match Required Under the Waiver				
Total Medi-Cal Costs	$1,414,518,988	$1,601,429,376	$1,698,386,447	$1,772,231,663
Estimated FMAP	51.36%	51.36%	51.36%	51.36%

FFP Under the Waiver	726,496,953	822,494,128	872,291,279	910,218,182
Required State Match	$688,022,036	$778,935,248	$826,095,168	$862,013,481
Estimated Sources of State Match				
EPSDT	$214,154,669	$260,541,208	$291,561,126	$319,225,090
Managed Care Allocations	194,535,670	194,535,670	194,535,670	194,535,670
Realignment Allocations	944,726,315	944,726,315	944,726,315	944,726,315
Total	$1,353,416,654	$1,399,803,193	$1,430,823,111	$1,458,487,075
Surplus of Realignment Required for Match	$665,394,618	$620,867,945	$604,727,943	$596,473,594

There are other sources of funds that the current MHPs, as county mental health departments, receive to provide mental heath services. Table S3, in **APPENDIX II-N**, shows the primary funding sources for mental health services, by county, for FY 1999-00 as reported through the SD/MC year-end cost report. The figures shown in Table S3 for the managed care allocation do not necessarily match allocation amounts due to the timing of expenditures and revenues (i.e., realignment revenue growth is not received until approximately eight months after the close of the fiscal year).

Realignment is the largest source of revenues, followed by FFP for the Medi-Cal services provided by the MHPs (labeled as "regular SD/MC (FFP only) on Table S3). FFP accounts for about one-quarter of the overall mental health revenues of county mental health departments. Other revenues and county overmatch (revenues provided by individual counties over and above what is required as part of the maintenance of effort) are the next largest source of revenues and account for about 15 percent of overall mental health revenues. None of these revenues are retained by the State nor does the State charge MHPs for any of these revenues. All these revenue sources fund expenditures incurred by county mental health departments.

O. Children with Special Health Care Needs

The State has submitted its initial annual report on children with special health care needs under the waiver and is in the process of preparing for the second report, which will be due in November 2002. A general description of the ways in which the waiver program meets the CMS criteria for children with special health care needs under Section 1915(b) waiver programs is provided as **EXHIBIT 7**.

P. Independent Assessment

The State is submitting an independent waiver assessment of the current waiver to CMS with this renewal request as required as a condition of waiver renewal in

the CMS approval letter of November 16, 2000. Consistent with CMS policy, except under unusual circumstances, the State expects that this will be the final independent assessment of the program.

III. Program Impact

A. Enrollment/Disenrollment

1. DHS administers the Medi-Cal beneficiary enrollment process. Beneficiaries are enrolled in the waiver program automatically, by virtue of being determined Medi-Cal eligible in a county where an MHP is operational.

2. Under the waiver program, auto-assignment of beneficiaries among plans does not occur. All beneficiaries are assigned to the MHP in the county of their residence.

3. Under the waiver program, there is no difference in the process for enrollment of special needs populations. All beneficiaries are enrolled in the program, regardless of special needs. MHPs are required to ensure that their contract hospitals provide psychiatric inpatient hospital services, within scope of licensure, to all beneficiaries who are referred by the MHP and to ensure adequate access to other specialty mental health services through a network of contracting and employed providers.

4. Beneficiaries who are eligible for both Medicare and Medi-Cal are mandatory participants in this waiver program. These beneficiaries, however, are free to access Medicare services from any willing Medicare provider. State and MHP responsibility for payment for dual eligibles is described below in Section III.B.6, Processing and Denial of Provider Claims.

5. Enrollment Materials

   a) At the beginning of the modified waiver program, the State notified all beneficiaries in writing of the availability of specialty mental health services through MHPs by mailing a notice to all Medi-Cal households prior to MHP start-up in the county. The initial mailing of the notice was in English and Spanish. The State provides on-going information on the program to new applicants through county welfare departments. The State has also provided translations of the notice in other threshold languages through county welfare departments. County welfare departments have primary responsibility for Medi-Cal eligibility determinations and, therefore, are a good location for reaching current beneficiaries and new applicants for Medi-Cal. The initial notices are included in **APPENDIX III-A-5-a**.

      The State has developed a revised notice (see **APPENDIX III-A-5-b**) for distribution through county welfare departments with input from program stakeholders, primarily the DMH Client and Family Member Task Force (CFMTF) and the Medi-Cal Policy Committee of the California Mental

Health Director's Association (CMHDA). The revision, however, was not finalized until March 2002. At this point, however, it is clear that the notice will need to be revised to meet the new annual notice requirement at Title 42, CFR, Section 438.10(f)(2). Although the revised notice would have been an improvement on the initial notices, the initial notices are adequate until the annual notice process is established by August 2003. The revised notice is provided as an information item, since it was discussed in the previous waiver renewal request.

b) When a beneficiary first receives non-emergency specialty mental health treatment services from an MHP, the MHP is required to provide the beneficiary, either in person or by mail, a brochure that describes: available services; the process for obtaining services, including the MHP's statewide toll-free telephone number; the MHP's beneficiary problem resolution process, including the complaint resolution and grievance processes; the beneficiary's right to request a fair hearing at any time before, during, or within 90 days after the completion of the MHP's beneficiary problem resolution process, and a description of the right to request a fair hearing whether or not the beneficiary uses the problem resolution process and whether or not the beneficiary has received a notice of action; and the process for obtaining a list of the MHP's providers that includes alternatives and options for cultural/linguistic-specific services. The MHP is required to make copies of the brochures available to Medi-Cal beneficiaries upon request. In addition, the MHP must offer the brochures in all of its identified threshold languages.

   The MHP beneficiary brochures will require extensive revision to comply with the new requirements of Title 42, CFR, Section 438.10 that must be implemented in August 2003. The State is currently considering developing a boilerplate brochure that complies with the general information requirements of the new rule, while allowing each MHP to include information specific to its own system.

c) Posted information and member brochures prepared by the MHPs include general information about services available and the complaint, grievance and fair hearing processes. The State did not include specific information about included and excluded diagnoses in the general notice to all Medi-Cal beneficiaries nor were the MHPs required to include this information in their informational member handbooks/brochures. The State believes that including this level of detail would increase the likelihood that beneficiaries would not call the MHP for assistance, thinking that they must know their diagnosis before attempting to access services. Beneficiaries are able to call the MHP's 24-hour toll free telephone number for information about mental health services for both included and excluded diagnoses. If the MHP ascertains that a beneficiary is seeking treatment

for an excluded diagnosis, the MHP refers that beneficiary to the appropriate agency or organization for treatment of his/her condition.

6. Beneficiary brochures and other program information are translated by each MHP into each threshold language for that county. A threshold language is defined in state regulation as a language that has been identified as the primary language of 3,000 beneficiaries or five percent of the beneficiary population, whichever is more. MHPs are informed of the threshold languages through DMH Information Notices, which sent by mail and available on the DMH website at www.dmh.ca.gov. DMH Information Notice No. 02-04 issued on May 29, 2002 provides the most recent information and is included as **APPENDIX III-A-6**.

7. Each MHP submitted and received DMH approval of an implementation plan under the modified waiver. Implementation plans are considered by DMH to be dynamic documents that continue to be the guiding document for MHP operations. Instructions for developing and submitting Implementation Plans were provided to MHPs in DMH Information Notice No. 97-06 and included as **EXHIBIT 5**. Implementation plans are routinely amended by MHPs as MHP processes change. Amendments are subject to DMH approval to ensure continuing compliance with state and federal requirements. One of the content areas of the implementation plan is a description of the languages in which written MHP information will be made available as required by Title 9, CCR, Section 1810.410 (see **EXHIBIT 4**) and the data supplied by the State regarding threshold languages described in Section III.A.6. above.

   MHPs were also required to develop and implement a plan for the provision of culturally competent services to beneficiaries as a means to increase access to services. Cultural competence plans (CCPs) were developed by each MHP and submitted to DMH for approval. The CCPs were approved through a process that included review by DMH Technical Assistance and Training (TAT) staff and the DMH Office of Multicultural Services. DMH Information Notice No. 02-03 issued on May 2, 2002, describes the current requirements for CCPs, including requirements that MHPs make information available to beneficiaries on the language and cultural competence of their provider networks (see **APPENDIX III-A-7**).

   Additionally, Title 9, CCR, Section 1810.410 (**EXHIBIT 4**), requires that, at a minimum, each MHP must provide a statewide toll free telephone number with linguistic capability in all languages spoken by beneficiaries that is available 24/7 and interpreter services in threshold languages at key points of contact. The State will be reviewing these informing requirements to ensure consistency with Title 42, CFR, Section 438.10.

8. Each MHP's implementation plan also includes a description of the methods the MHP will use to provide general information to persons with visual or hearing impairments. Annual Program Compliance Division review reports indicate that the MHPs use a variety of methods, including access to TDD devices, video tapes, sign language interpreters, translated documents in Braille, and one to one verbal explanations of written materials to meet these requirements.

B. Services

1. Covered Services (see **EXHIBIT 4**, Title 9, CCR, Sections 1810.201 through 1810.254 for definitions)

   a) Psychiatric inpatient hospital services

   b) Rehabilitative mental health services, including mental health services, medication support services, day rehabilitation, day treatment intensive, adult residential treatment services, crisis intervention, crisis stabilization, crisis residential treatment services, and psychiatric health facility services

   c) Psychiatrist services

   d) Psychologist services

   e) EPSDT supplemental specialty mental health services, including TBS.

   f) Targeted case management

2. Prior Authorization

   a) All services under this waiver program except emergency psychiatric inpatient hospital services and the related psychiatric inpatient hospital professional services may require prior authorization from the MHP, at the discretion of each MHP.

   b) Primary care services are available outside the waiver program. Under the waiver program, rehabilitative and case management specialty mental health services may require prior authorization from the MHP. All Medi-Cal services not covered by the waiver will be obtained in the same manner as under the Medi-Cal program without the waiver.

   c) The following Medi-Cal services under the waiver program do not require prior authorization from the MHP:

- Emergency psychiatric inpatient hospital services

- Emergency psychiatric health facility services

- Psychiatric inpatient hospital professional services that do not exceed one service for each day the beneficiary receives acute psychiatric inpatient hospital services.

3. Emergency and Family Planning Services

   In accordance with federal requirements, emergency and family planning services are not restricted under the waiver. Family planning services are not covered by MHPs. Hospital emergency room visits and related professional services by providers who are not mental health specialists are not covered services under this waiver, whether or not the emergency room visit is due to an emergency medical condition. Professional services in an emergency room provided by psychiatrists and psychologists are covered under the waiver program, however, all such services are not considered emergency services.

   For those services covered by the MHP, the definition of emergency services will be the same under the waiver as it is without the waiver. Emergency services are those services required for alleviation of severe pain, or immediate diagnosis and treatment of unforeseen medical conditions, which if not immediately diagnosed or treated, could lead to disability or death. The State has established MHP requirements which operationalize this definition in terms of psychiatric inpatient hospital services, since circumstances under which a mental health condition, if not immediately diagnosed and treated, could lead to disability or death are significantly different than those that exist for other emergencies. These requirements are described in **APPENDIX III-B-3**. The State believes these requirements are consistent with the definition of emergency medical condition in Title 42, CFR, Section 438.114; however, a waiver is requested to the extent necessary.

4. Federally Qualified Health Center (FQHC) Services

   FQHC services are not included under the waiver. Beneficiaries may receive FQHC services outside the waiver program, if they choose. Some MHPs contract with FQHCs for limited specialty mental health services. Some county governments operate their own FQHCs separately from county mental health departments. Several MHPs have memorandums of understanding (MOUs) with FQHCs for physical health care coordination.

5. EPSDT Services

The EPSDT benefit is a mandated component of the California Medi-Cal Program. The waiver program includes EPSDT specialty mental health services for full-scope Medi-Cal beneficiaries under the age of 21. All other EPSDT services are available outside of the waiver program. EPSDT specialty mental health services include those services, called EPSDT supplemental specialty mental health services, that are only available to EPSDT eligible beneficiaries, in addition to those specialty mental health services that are available to all beneficiaries.

Under the waiver program, EPSDT specialty mental health services are delivered through the same basic system that the MHPs use to provide all other specialty mental health services. The two key differences for the delivery of EPSDT specialty mental health services are:

a) EPSDT specialty mental health services are considered medically necessary when they are necessary to correct or ameliorate an included mental illness or condition, consistent with California's standard for EPSDT services in the FFS/MC program; and

b) The SGFs available for EPSDT services above a baseline amount established for each MHP are not capped, whereas SGFs for other specialty mental health services are set at a fixed annual allocation.

An examination of statewide data indicates that services to full-scope Medi-Cal beneficiaries under the age of 21 have increased significantly since FY 1995-96, the first full year under the waiver and the year in which SGFs became available to augment county funds as matching funds for FFP for expanded services to this population. The growth rate in dollars spent on EPSDT services has been at least 26 percent per year since FY 1995-96; however, growth has not been consistent among all MHPs. The average penetration rate (the number of eligibles divided by the number of unduplicated clients) for the waiver program for EPSDT for FY 2000-01 is 5.18 percent. Although the penetration rate has increased each year, it continues to be lower than the estimated incidence of mental illness in this population of nine percent to thirteen percent. More detailed information on each MHP is provided in **APPENDIX III-B-5-a**. DMH is currently exploring clinically appropriate methods for ensuring appropriate access, while minimizing unnecessary services.

The most recent legal decision that impacts EPSDT specialty mental health services is the Emily Q. v. Bontá lawsuit, which mandated that the State provide TBS as a new EPSDT supplemental specialty mental health service beginning July 1999. A permanent injunction and final judgment issued in the case on May 10, 2001 confirms the initial injunction and adds new requirements at both State and local levels that are expected to increase TBS

utilization. The State's notice describing TBS is provided in **APPENDIX III-B-5-b**.

6. Processing and Denial of Provider Claims

a) Psychiatric Inpatient Hospital Services:

For a claim to be paid under the waiver program, a MHP must approve payment for the services. For services provided by FFS/MC hospitals, the MHP approves a Treatment Authorization Request (TAR). For SD/MC hospitals, the county MHP approves the hospital stay through a TAR or delegates this authority to the hospital's Utilization Review Committee (URC).

If a MHP does not authorize a service requested by a FFS/MC hospital, the hospital is notified by the MHP. The denied TAR is submitted to Electronic Data Systems (EDS), the fiscal intermediary under contract to DHS to administer the FFS/MC claims payment system, and entered into the claims database. SD/MC hospitals are notified either by the MHP or internally by the hospital's URC.

The reimbursement process works as follows for FFS/MC hospitals. The provider submits a TAR to the MHP and a claim to EDS. The MHP submits the approved TAR to EDS. When EDS has a claim and an approved TAR, it notifies the State Controller's Office (SCO) of the approved claims and SCO submits payment to the hospital. The SCO provides reports for DHS and DMH that allow the State to offset each MHP's realignment funds for the local portion of the Medicaid match. FFP is obtained through the State's Health Care Deposit Fund using the same mechanism used for the FFS/MC program. For SD/MC hospitals, the county directly pays the state Medicaid match to the provider and submits a claim through the SD/MC claims processing system to obtain the FFP. This process will continue for the renewal period. Please refer to **APPENDIX III-B-6** for a flow chart of the reimbursement process.

b) Providers of Specialty Mental Health Services other than psychiatric inpatient Hospital Services

The MHP in each county may require that providers obtain MHP payment authorization of any or all specialty mental health services covered by the waiver program as a condition of reimbursement for the service. MHPs

use MHP employees or contract providers to deliver most services. For contract providers, MHPs negotiate rates of payment and typically provide full payment to the provider for approved services within 30 days of receipt of the provider's invoice. The MHP receives reimbursement for the FFP portion of these invoices through the SD/MC claims processing system. A flow chart of this reimbursement process is included in **APPENDIX III-B-6**

c) Crossover/Dual Eligible Claims

The SD/MC claims processing system makes payments of coinsurance and deductibles for all covered specialty mental health services provided to persons with both Medi-Cal and Medicare eligibility, when the provider is either the MHP or a contract provider who submits cost reports (in most cases, former SD/MC clinics). When submitting the SD/MC claim for dually eligible beneficiaries, the MHP enters a specific code that indicates that Medicare payment has already been made and that the amount claimed is what Medicare does not cover. This coding system has been in place in the SD/MC program since before the waiver program was implemented.

EDS pays the coinsurance and deductibles for Medicare services delivered by FFS/MC hospitals and independent practitioners (in most cases, former FFS/MC psychiatrists, psychologists, etc., who do not prepare cost reports under the waiver). These payments are not included in the waiver program. Historical Medicare coinsurance and deductible costs have not been included in SGF allocations to the MHPs.

MHPs are responsible for full Medi-Cal coverage of services to dually eligible beneficiaries when Medicare benefits have been denied or exhausted and must use the appropriate claims payment/processing system based on the type of service and provider.

C. Medi-Cal Specialty Mental Health Services Providers

1. Numbers and Types of Providers

The table below presents a summary of the number of providers before and during the waiver renewal period:

PROVIDER TYPE	1996-97	1997-98	1998-99	1999-00	2000-01	2001-02
TOTAL FFS/MC HOSPITALS	204	200	195	193	195	192
FFS/MC HOSPITALS PROVIDING SERVICE	121	122	118	113	105	95
SD/MC HOSPITALS	29	27	23	23	23	24
SD/MC ORGANIZATIONAL PROVIDERS	878	1012	1124	1261	1445	1499
FFS/MC PRACTITIONER PROVIDERS	3314	N/A	N/A	N/A	N/A	N/A

The total FFSMC Hosptials include all in state and border state facilities
with psychiatric beds that are indicated as active during each of the fiscal years.
Data for FFS/MC Practitioner Providers is not available after FY 1996-97
Data Source: State of CA Dept. of Mental Health, Statistics and Data Analysis, 7-5-2002

The numbers in the table have been adjusted for this third waiver renewal request and reflect more accurate counts of providers than was provided in the second waiver renewal request. At the time of the second waiver renewal there were a number of SD/MC providers that were inactive but had not notified the MHP or DMH of their status. Solano and San Mateo County providers were also inadvertently included in the prior counts. DMH has made efforts to ensure that inactive providers have been accounted for in the current numbers. In addition, DMH data collection methods have improved allowing for more accurate collection of provider information.

The number of FFS/MC psychiatric inpatient providers decreased slightly from FY 1996-97 (prior to the first waiver renewal period) through FY 2001-02. This was due to a number of hospitals closing their psychiatric units. The number of hospitals actually providing psychiatric inpatient hospital services to Medi-Cal beneficiaries continues to decrease. 121 FFS/MC psychiatric inpatient hospitals provided services in FY 1996-97, while 95 FFS/MC psychiatric inpatient hospitals provided services in FY 2001-02. The number of SD/MC hospitals has also decreased from 29 in 1996-97 to 24 in FY 2001-02. The decline in participating hospitals is a result of reductions that are occurring for all populations in California and nationally, not a result of the waiver program alone. To some extent, the decline represents a positive trend toward early intervention and community-based, rather than institutional, treatment of individuals in crisis. On the other hand, ensuring the availability of psychiatric inpatient hospital services, when necessary, is essential to continued successful operation of the waiver program. California continues to explore potential solutions to the issue.

The number of SD/MC organizational providers has increased from 878 in FY 1996-97 to 1,499 in FY 2001-02. It should be noted that SD/MC organizational providers consist of a varying number of actual practitioners who serve Medi-Cal beneficiaries. Information is not available at the State as to the actual total number of SD/MC practitioners who are employed by SD/MC organizational providers. Information on SD/MC organization providers by MHP for FY 1996-97 through FY 2001-02 is provided in **APPENDIX III-C-1**.

Data on paid claims for FFS/MC psychiatrists and psychologists for FY 1996-97, prior to the first waiver renewal period, revealed that 3,314 psychiatrists and psychologists received Medi-Cal payments during that year. It should be noted that since FY 1996-97 was prior to Medi-Cal Specialty Mental Health Services Consolidation, some of these claims may be for services to beneficiaries who would not have met medical necessity criteria developed for consolidation, so the number may be somewhat inflated. MHPs were only required to obtain one provider number for each practitioner type in their FFS/MC network, so there is currently no information available on the number of practitioner providers statewide who contracted with MHPs.

Medi-Cal Specialty Mental Health Services Consolidation enabled MHPs to expand the range of practitioner types in their individual provider networks to include MFTs, LCSWs and RNs, as described in this document. This allows for greater ability to increase the number of available network practitioner providers. State Medi-Cal oversight reviews that were conducted during the past and present waiver periods found that, in general, MHPs had maintained or increased the number of practitioner providers compared to those available to beneficiaries under FFS/MC.

2. Provider Requirements

All MHPs are currently county mental health departments and are qualified to serve as MHPs by virtue of their experience with the public mental health system including the SD/MC program. Counties operate as MHPs under the sole source exemption granted by CMS for the previous waiver periods and requested again for this waiver renewal and under state law, which provides for automatic contract renewal so long as counties continue to comply with requirements.

For provider qualifications and requirements under the current and proposed waiver renewal program, please refer to State regulations in Title 9, CCR, Sections 1810.425 (Hospital Selection Criteria) and 1810.435 (Individual, Group, and Organizational Provider Selection Criteria). The regulations are included as **EXHIBIT 4**.

APPENDIX III-C-2 provides model contracts for psychiatric inpatient hospital services providers and individual and group professional services providers provided to MHPs in 1994 and 1997 respectively. The inpatient hospital model contract was adapted from a contract used by the California Medical Assistance Commission (CMAC) for the Selective Provider Contracting Program. The professional services contract is a contract currently being used

in the San Mateo County field test. These are included as examples only. Actual contracts will vary from the examples.

3. Changes of Provider

   Under the current waiver and established in regulations (**EXHIBIT 4**), MHPs, at the request of the beneficiary, will provide a beneficiary with an initial choice of a service provider, whenever feasible. The MHP may limit the beneficiary's choice to either a choice between two of the individual providers contracting with the MHP or a choice between two of the persons providing services who are employed by, contracting with or otherwise made available by the group or organizational provider to whom the MHP has assigned the beneficiary.

   MHPs, at the request of the beneficiary, will also provide beneficiaries an opportunity to change providers, whenever feasible. The MHP may limit the beneficiary's choice of another person to provide services to either an individual provider contracting with the MHP or to another person providing services who is employed by, contracting with or otherwise made available by the group or organizational provider to whom the MHP has assigned the beneficiary.

   Generally, these choices are available to all beneficiaries. Choices are not feasible in only a limited number of situations, usually in MHPs in small counties. In small MHPs, one psychiatrist, for example, may be all that is needed and available to meet beneficiaries needs, but a choice would not be available to the beneficiaries.

4. Differing Program Aspects

   With this third waiver renewal request, the State is proposing to continue the current program design as described in the second waiver renewal request approved November 19, 2000. Although implementation of the new Medicaid managed care regulations in August 2003 will involve a number of changes to the technical operations of the waiver program, the core elements will remain intact. The State expects to continue its on-going dialogue with CMS through monthly conference calls and to use this forum to discuss the implementation details.

5. Reimbursement of Providers

   As appropriate to the specific services covered under the applicable waiver period, MHPs claim FFP on a fee-for-service basis through the SD/MC claiming system for specialty mental health services, except psychiatric inpatient hospital services in FFS/MC hospitals, subject to annual cost

reconciliations. The SD/MC claims payment system was designed to meet the unique needs of SD/MC services and providers under the State Plan in terms of services, state funding sources, and federal cost reimbursement methodologies. The original waiver program and subsequent waivers did not change the basic payment system and, therefore, did not lend itself to shifting claims payment to the fiscal intermediary system through EDS that the State uses for most FFS/MC services.

Psychiatric inpatient hospital services in FFS/MC hospitals are claimed through the FFS/MC claiming system. The State provides the current MHPs with a fixed annual allocation of SGFs based primarily on historical FFS/MC expenditures for the covered specialty mental health services. If a MHP is selected through the Request for Application process, the State will provide the MHP with a fixed annual allocation based primarily on historical expenditures in both FFS/MC and SD/MC. The MHP is at risk for the required State match for any expenditures above the allocated amount, with the exception of expenditures for EPSDT specialty mental health services (all specialty mental health services provided to EPSDT eligible children other than psychiatric inpatient hospital services). See Section V, "Cost Effectiveness," for additional information on the EPSDT funding arrangement.

In addition to setting the reimbursement methodology for the MHPs, the State has also established the following requirements for MHP reimbursement arrangements with participating providers:

Reimbursement for FFS/MC psychiatric inpatient hospital services will continue the methodology set under the original Medi-Cal Psychiatric Inpatient Hospital Services Consolidation waiver program. Contract providers will be reimbursed on prospective per diem rates negotiated between the provider and the county MHP and will not be subject to retrospective cost settlement. Emergency psychiatric inpatient hospital services provided in non-contract hospitals will be reimbursed based on the weighted average rates for contract providers calculated by region, and will not be subject to retrospective cost settlement. Claims will be processed by EDS.

Reimbursement for mental health professionals licensed to practice independently will be based on negotiated rates between the independent practitioner or group of independent practitioners and the MHP and may include case rates or capitated payments from the MHP to providers. The payment will not exceed the SD/MC statewide maximum allowable (SMA) rates and will not be subject to the cost settlement or negotiated rate reimbursement methodology in California's State Plan for SD/MC services.

Reimbursement for SD/MC psychiatric inpatient hospital services will be in accordance with California's State Plan for SD/MC reimbursement.

Reimbursement for rehabilitative mental health services and case management services, including, in some cases, services previously provided in FFS/MC clinic settings, will also be in accordance with California's State Plan for SD/MC reimbursement.

6. Referrals

Under the waiver program, referrals to the MHP for specialty mental health services may be received through beneficiary self-referral or through referral by another person or organization, including but not limited to physical health care providers, schools, county welfare departments, other MHPs, conservators, guardians, family members, and law enforcement agencies. MHPs will maintain a written log of initial contacts (telephone, written, or in-person) by beneficiaries requesting specialty mental health services from the MHP. MHPs will provide a referral to a physical health care provider when the MHP determines the mental health condition would be responsive to physical health care based treatment.

If a beneficiary is experiencing a psychiatric emergency, he or she may be taken directly to a hospital by family, mental health crisis staff or law enforcement personnel, and the MHP will be notified by the hospital of the emergency admission. Beneficiaries may also access psychiatric inpatient hospital services by referral through the MHP to a hospital. Clinics and other service agencies (e.g., social services, schools, police, juvenile justice, probation, vocational services) may also refer a beneficiary for psychiatric inpatient hospital services, although the MHP is responsible to authorize services, and the referral is normally made by the service agency through the MHP.

7. Medi-Cal Claim Form

Authorization of psychiatric inpatient hospital services will occur by the same process that has been in place since the initial waiver period. For FFS/MC hospitals, the TAR form is initiated by the provider and approved by the MHP. The MHP uses a county stamp and a numeric county code to allow the fiscal intermediary to verify that the authorization is valid. Before payment is made, the TAR must be matched with a claim form submitted by the provider. The claim line identifies the TAR control number from the TAR submitted to the MHP. SD/MC hospitals are either county-operated or contractors of the county MHP. In most cases, authorization is done through a URC process. MHPs claim FFP through the SD/MC claims processing system. Since claims may only be made by MHPs, unauthorized use of the SD/MC system to claim FFP for psychiatric inpatient hospital services would not be possible.

Individual and group providers will submit claims to the MHP based on the CMS Common Procedural Coding System (HCPCS) or based on SD/MC service function codes, if required by the contract between the provider and the MHP. The MHP may require prior authorization, except for emergency services. The MHP will use standard industry provider claim forms or, as appropriate, may develop its own claim forms. For providers billing HCPCS codes, the MHP will convert the HCPCS codes into service function codes based on a crosswalk established in regulation (see **EXHIBIT 4**, Title 9, CCR, Section 1840.304) and obtain FFP through the SD/MC claims processing system.

Organizational providers, primarily traditional SD/MC clinic providers, will either be county-operated or contractors of the county MHP. These providers will receive negotiated rates or cost based reimbursement using the payment methods established in the State Plan. The MHP will claim FFP for these services through the SD/MC claims processing system.

The State is currently involved in adapting its claiming systems to accept transactions that meet the requirements of the regulations implementing the Health Insurance Portability and Accountability Act. Although it is clear that a significant number of technical changes will be required to achieve compliance, at this point, it appear that the basic payment mechanism will remain.

IV. Access to Care and Quality of Services

A. Access to Services Under the Waiver Program

1. General Information

This waiver program is designed to improve access to and the quality of specialty mental health services for Medi-Cal beneficiaries. The waiver assures an adequate amount of services within a reasonable geographic distance from the residences of the individuals enrolled under the waiver. Furthermore, access to emergency and family planning services are not restricted under the waiver. Please note that the waiver program covers specialty mental health services only, so medical emergency room visits and family planning services are not affected. Access standards for MHPs are governed by state regulations. Under the waiver program, regulations focus on assuring an adequate number of providers and additional factors, such as timeliness of services for urgent conditions. For examples of access-related state regulations, see **EXHIBIT 4,** Title 9, CCR, Sections 1810.310, 1810.345, 1810.405, 1830.220, and 1830.225.

2. Assurance That There is an Adequate Provider Network in Each County

Each MHP is responsible to assure that there is an adequate provider network in that county, through an appropriate combination of programs operated directly by the MHP and contracts with organizational providers and independent practitioners. The provider network and criteria used to measure access are described in each MHP's implementation plan. Because counties in California are very different, the State has not set statewide standards for travel time/distance to providers, the number of patients a clinical provider may treat, or beneficiary/provider ratios. MHPs are expected to address these areas through their individual Quality Management programs. The State requires each MHP to demonstrate in its implementation plan, verified through annual reviews, that access to services will be no less than it was prior to the waiver. MHPs were required to adequately address this issue to receive state approval of the implementation Plan. See **EXHIBIT 5** for implementation plan requirements. In addition, state regulations establish basic access requirements (e.g., **EXHIBIT 4**,
Title 9, CCR, Sections 1810.310, 1810.345, 1810.405, 1830.220, and 1830.225).

3. Access for Persons With Excluded Diagnoses or Diagnoses Which Would be Responsive to Physical Health Care Treatment

The medical necessity criteria used to determine whether beneficiaries need specialty mental health services from the MHPs is a three-step decision making process. First the MHP determines whether the beneficiary's mental condition is one of the included diagnoses. If an included diagnosis is present, then the MHP determines whether the beneficiary meets the impairment criteria, for example, has a significant impairment in an important area of life functioning. If the impairment criteria are also met, the MHP then determines whether specific intervention criteria are met. If the condition would be responsive to physical health care based treatment (usually treatment by a primary care physician), the intervention criteria will not be met and a service from the MHP will not be medically necessary. See **EXHIBIT 4**, Title 9, CCR, Section 1830.205, for the specific medical necessity criteria.

Intervention criteria, rather than diagnosis, differentiate the responsibilities of the physical health care providers or health plans from the responsibilities of the MHPs for included diagnoses. Primary care providers (PCPs) and other physical health care providers may provide any "primary" mental health services that are allowed within their scopes of practice to treat any mental health diagnosis. The issues that determine a PCP's need to refer a beneficiary to the MHP include the need for additional time and services not generally offered in a primary care setting, services that need to be provided in a beneficiary's home or other non-office setting, and the level of comfort a PCP may have in treating a specific mental health diagnosis. Services to treat excluded diagnoses, whether provided by mental health specialists or PCPs, are not covered by the MHPs.

MHPs are required in regulation (**EXHIBIT 4**, Title 9, CCR, Section 1810.370.) to establish an MOU with Medi-Cal physical health care plans serving Medi-Cal beneficiaries in each MHP's county to deal specifically with referral protocols that will operationalize this division of responsibilities. DHS has issued two policy letters further clarifying the content of the MOUs and the division of payment responsibilities. MHPs and physical health care plans have generally reached agreement on the issues that must be addressed in the MOUs and successfully negotiated them under the current waiver. It can be expected that these MOUs will continue during the requested renewal period.

MHPs are required to offer mental health consultation, including medication consultation, to PCPs, whether the PCP is serving beneficiaries in FFS/MC or enrolled in a physical health care plan, to facilitate appropriate treatment and, when needed, referral to the MHP for specialty mental health services.

When a beneficiary has a mental health condition that would be responsive to physical health care based treatment, there are two methods by which MHPs may make referrals. The first, discussed above, is to refer the beneficiaries to

their physical health care plan using the referral protocols outlined in the required MOU. In addition, if a beneficiary is not enrolled in a physical health care plan, MHPs will refer the beneficiary to a physical health care provider. For children and adolescents, this referral can be affected through the county's Child Health and Disability Prevention (CHDP) program, which will connect beneficiaries to local physical health care providers. MHPs and local CHDP programs are also working together to establish specialty mental health referral networks for children with excluded diagnoses. For adults, MHPs may refer beneficiaries to the State's Health Care Options program in counties where physical health care plans are available, to individual local providers including Federally Qualified Health Centers (FQHCs) and Rural Health Clinics, or to the medical society in the area.

4. Access to Services in the Event of a Dispute Between the MHP and a Physical Health Care Plan

   One required component of the MHP and physical health care plan MOUs is a process for resolving disputes between the plans, including agreement on a method for assuring the provision of care during the dispute resolution process. During Medi-Cal oversight reviews, it was confirmed that, in actual practice, MHPs agree to provide services when there is a dispute over responsibility for providing care.

5. How Beneficiaries Access a Specialty Mental Health Provider Under the Waiver Program

   Although the State does not require that a beneficiary be referred by a PCP to receive Medi-Cal specialty mental health services, PCPs are a major source of referrals. Depending on the referral structure of the specific MHP, beneficiaries who are referred are either linked directly with an individual provider or scheduled for an initial assessment by an MHP assessment team and then linked to a treating provider as appropriate. A similar process is used by the MHP for beneficiaries who self-refer and those who are referred by hospitals, clinics and other service agencies (e.g., CHDP, social services, schools, police, juvenile justice, probation, vocational services). All beneficiaries receive a notice containing the MHP's 24-hour information number and advising them of the availability of a member handbook/brochure providing more detailed information on the MHP's program and grievance procedures. MHPs make provider lists available to beneficiaries upon request.

6. Access to Care for Foster Children Placed Out-of-County

   MHPs are required to provide emergency and urgent services to their beneficiaries whether or not the beneficiary is currently in the MHP's

geographic area. When beneficiaries are placed out-of-county by the foster care program or through other legal placement processes, the MHP must also provide routine services to the beneficiary in the geographic area in which the beneficiary is placed. MHPs addressed this critical area of coordination in their implementation plans (see **EXHIBIT 5** for state requirements). The obligation to serve foster children who have been placed out-of-county is specifically covered in state regulations (see **EXHIBIT 4**, Title 9, CCR, Section 1830.220).

MHPs continue to explore ways to improve their ability to provide timely access to services for beneficiaries placed out-of-county. In 1998, under the first waiver renewal period, they selected CMHDA to serve as an administrative service organization (ASO) to authorize and pay for basic outpatient specialty mental health services needed by foster children who are placed out-of-county. CMHDA selected ValueOptions, a California licensed specialty health care service plan, as its subcontractor to perform the ASO functions with providers. CMHDA coordinates ASO functions with the participating MHPs. The start date of the ASO agreement between CMHDA and Value Options was November 1, 1999. **APPENDIX IV A-6-a** provides the current contract between CMHDA and Value Options. **APPENDIX IV A-6-b** is an example of the contracts between the ASO and the individual MHPs. Value Options began paying claims January 2000.

Generally, the services provided through the ASO include assessments, therapy, and medication management. The ASO simplifies and streamlines the authorization and payment processes, so providers of service will not need to have contractual relationships with multiple counties. The ASO also credentials providers for the participating MHPs, so providers only need to go through the credentialing process once.

The ASO routinely provides feedback to the MHP of the beneficiary, so the MHP may approve the child's treatment plan and provide for other services, such as day treatment or case management, as needed. The State believes this process has been an improvement over the previous process in which each MHP must establish out-of-county provider networks or recruit providers on short notice when a beneficiary is placed out of county.

As of June 2002 approximately 10,000 children have been served through the ASO. There are about 5,000 active at any one time due to some children being ineligible, going back to their home county or aging out. Only six MHPs have declined to contract with the ASO, because of their small size (Alpine, Modoc, Colusa, Inyo), conflicts with its federal corporate integrity agreements (Ventura), or a determination that the MHP can provide adequate access to out-of-county children through providers contracting directly with the MHP

(Contra Costa). The ASO administration anticipates the program to grow at the rate of about 3,000 children per year.

Because of the success of the ASO, MHPs are considering expanding the scope of the ASO's duties within the time frame of the third renewal request to include a broader range of services and out-of-county populations in addition to foster children (e.g., telemental health services).

B. Grievances and Appeals

1. Grievances and Appeals under Title 42, CFR, Subpart F

Significant technical revisions to the State's current beneficiary problem resolution processes will be required by the new Medicaid managed care regulations to be implemented August 2003. The State expects to have the new system in place as required, but details must be worked out through discussions with the MHPs and input from stakeholders. The information on beneficiary compliant, grievance and appeal processes that follows in this section reflects only the current processes that will be in effect through August 2003.

2. Complaint and Grievance Processes

The current and proposed renewal waiver program includes a two-level beneficiary problem resolution process. The basic requirements are set in state regulations, which are provided as **EXHIBIT 4**, Title 9, CCR, Section 1850.205. The regulations require that:

a) MHPs have an informal complaint process;

b) MHPs have a formal grievance process with two levels of review within the MHP and with 30 days to resolve and notify the beneficiary in writing at each level of review;

c) Verbal and written information regarding beneficiary problem resolution processes is provided at the time of beneficiaries first access services and periodically thereafter;

c) Complaint/grievance information and forms are posted in prominent locations with self-addressed envelopes;

d) A specific staff person is designated to provide information on requests as to status of a beneficiary's grievance;

e) An expedited grievance process is available for Medi-Cal funded residential programs.

The beneficiary problem resolution process in each MHP is monitored by the DMH TAT Section and through the formal Program Compliance reviews. If deficiencies are noted, a plan of correction is required. If deficiencies are not corrected within specified timeframes, the State may take a number of actions authorized by Title 9, CCR, Sections 1810.380 (**EXHIBIT 4**). This regulation permits the State to impose sanctions, including fines, penalties, withholding of payments, special requirements, probationary or corrective actions, or other actions deemed necessary to prompt and ensure contract and performance compliance. Additionally, the State has the authority in statute and regulations to terminate an MHP contract if the MHP's performance does not meet minimum standards.

Within the MHP, the beneficiary problem resolution process identifies issues to be transmitted to the MHP's Quality Improvement Committee (QIC), administration or to another appropriate body within the MHP to implement needed action.

The grievance procedure provides for a grievance log and requires the recording of each grievance within one working day of the receipt of the grievance. MHPs provide annual reports to the State on their grievance processes. Please refer to **APPENDIX IV-B-1,** which provides a summary of the grievance reports. MHPs have been operational for at least four years under the current waiver program and volume of grievances included in the reports has grown as expected. Although the number of grievances in the smaller MHPs does not lend itself to useful analysis, the State is beginning to have enough data for trend analysis of MHPs in medium and large counties. TAT Section staff will begin analysis once the reports for FY 2001-02 are received in October 2002.

Under the waiver program, beneficiaries are informed of their grievance and fair hearing rights in the following manner. When a beneficiary first receives non-emergency specialty mental health services from an MHP, the MHP provides the beneficiary, either in person or by mail, a brochure that describes the program, the process for obtaining services through the MHP and the process for resolving grievances and complaints. In addition, the MHPs ensure that copies of the brochures are available to Medi-Cal beneficiaries upon request. MHPs are required to post notices in provider offices describing the grievance and fair hearing processes, as well as ensure that grievance forms are available at these locations. The MHP provides beneficiaries with written notice of their grievance and state fair hearing options as a part of the written decision at each level of the MHP's grievance process. The MHPs

provide beneficiaries with a written notice of action when the MHP denies, modifies, reduces, terminates or defers a provider's request for MHP payment authorization. Beneficiaries also receive quarterly notices through the regular Medi-Cal program that describe the fair hearing process. Please refer to **EXHIBIT 4**, Title 9, CCR, Sections 1850.205 and 1850.210.

2. Appeal Processes

a) Beneficiary Fair Hearing Process

Beneficiaries have a right to a fair hearing when one is requested within specified timelines when services are denied, modified, reduced, terminated, or deferred. When continuing services are reduced from the previously approved level or terminated, beneficiaries who file timely requests for fair hearings are entitled to services pending the outcome of the fair hearing. Please refer to the last paragraph above under Section: IV.B.1., for a description of the process for informing beneficiaries of their fair hearing rights. Beneficiaries have a right to access the fair hearing process instead of or at any time during the grievance process.

APPENDIX IV-B-2-a includes a table displaying the total number of hearings per year since 1998 statewide and for three MHPs selected as a representative sample (Alameda, Los Angeles and Sacramento). The State anticipated about 100 hearings a year once the waiver program was fully implemented. Fair hearings for 2000 and 2001 seem to indicate the estimate was reasonable accurate; however, there are already 77 hearing requests for 2002, so there may be an upward trend in process. Tables displaying the basic disposition of the fairing hearing cases by year statewide and for Los Angeles are also included. The data show that the overwhelming majority of the cases are dismissed or withdrawn. The State believes this is a factor of the option provided to beneficiaries to take their issues directly to fair hearing without going through the MHP grievance process, i.e., that once the MHP is advised of the fair hearing request, the MHP works with the beneficiary to resolve the issue directly. The State will be working with the data over the next year to confirm this conclusion and expects to develop data that will identify trends in the kinds of issues for which hearings are requested.

b) Provider Appeals

A formal provider appeals process regarding MHP denial of payment for services has been in effect since the initial waiver period. A formal provider appeal is initially submitted to the MHP. A second level appeal to DMH is available when an appeal concerning the denial or modification of an authorization request for emergency services is denied by the MHP on the basis of medical necessity criteria or timelines not being met. See **EXHIBIT 4**, Title 9, CCR, Section 1850.305, for the applicable state requirements. Between July 1, 1999 and June 28, 2002 a total of 6,597 second level provider appeals were received by DMH. DMH has completed 5,794 of these appeals. Consistent with the findings from 1998, approximately 87 percent were upheld as denied or modified by the MHP and 12 percent were reversed. **APPENDIX IV-B-2-b** provides an overview organized by county and facility of the appeals received and decisions rendered between July 1, 1999 and June 28, 2002. The State is exploring options for handling second level provider appeals more efficiently. Options have included the elimination

C. Monitoring Access

1. Medi-Cal Oversight Process

a) General Information on the Oversight Process

Under the waiver program, a review process has been developed to monitor service access. Reviews are conducted annually for each county by a team composed of team leaders from DMH Program Compliance Division, staff from the System of Care Division, consumers and family members, and MHP peer representatives. The review team also included DMH licensed mental health professionals to address clinical aspects of the review, particularly the chart review component. The reviews focus on areas of the waiver program seen as crucial for the continued success of the program. The review protocol includes items that evaluate the MHP success in ensuring access to services, having an active quality management process, providing for the integration of culturally competent standards of care, fulfilling MHP reporting requirements, and having an accessible beneficiary protection process. Please refer to **EXHIBIT 6** for the review protocol that will be used for FY 2002-03 during the third renewal period.

The protocol is revised annually by an advisory committee that was established by DMH in FY 1999-00 and mandated in statute in FY 2000-01. The Compliance Advisory Committee (CAC) is comprised of DMH staff from Program Compliance Division, Systems Implementation and Support Branch and the Office of Multicultural Services; the DMH

Medical Director, CMHDA; and other stakeholder organizations. **APPENDIX IV-C-1-a1** documents the current CAC membership. Subsequent review protocols developed during the proposed renewal period will continue to focus on improving the efficiency of the review process and adjusting to changes in MHP requirements, including requirements related to the new Medicaid managed care regulations. **APPENDIX IV-C-1-a2** summarizes the findings obtained from the FY 1999-00 and FY 2000-01 compliance reviews.

During FY 2001-02 DMH Program Compliance Division piloted a process to complete the review cycle utilizing a combination of desk audits and on-site reviews. Based on findings from the last three years of on-site reviews, a small number of MHPs (14) were the subject of desk audits as opposed to on-site reviews. This pilot was initiated in early 2002 and will continue to be a pilot project for FY 2002-03. The efficacy of continuing to conduct desk audits versus field reviews during FY 2003-04 will be a subject of discussion for future CAC meetings.

b) State Strategy for Monitoring Quality, Access, Consumer Education, Outreach, and Cost Effectiveness

The implementation plan requirements (**EXHIBIT 5**) contain items regarding quality, access, consumer education and outreach. The components of the implementation plan continue to be mandatory. MHPs are held accountable regardless of what contracting approaches the MHP may use. The State conducts annual reviews of quality of care and access as described in Section IV.C.1.a. above for each MHP to assure compliance with the implementation plan, the contract with DMH, and regulatory requirements. In addition, the State assigns contract managers from the TAT Section to each of the MHPs. TAT staff are responsible for day-to-day monitoring of and technical assistance to the MHPs. TAT staff monitor MHPs in their assigned region on a continuous basis through frequent telephone contacts, analysis of data and site visits. On-going monitoring of requests and outcomes of state fair hearings also provide TAT staff with indicators of access problems. TAT staff typically have several years of analytical experience with public mental health programs. To the extent possible, the section also recruits for individuals who are licensed mental health professionals. The section currently employs one RN as a contract manager. When clinical expertise is needed, TAT staff have access to licensed mental health professionals in other areas of DMH.

DMH has developed strategies for review and oversight of MHPs' provision of services and utilization of State and Federal funds for the EPSDT specialty mental health services, because of the continuing expansion of

these services over the past few years. These strategies are in addition to the annual oversight reviews DMH currently conducts for all MHPs. There are three major components of DMH efforts currently in place to assure adequate, appropriate, and cost-effective services under the EPSDT benefit:

- DMH EPSDT FY 2000-01 Field Audits;
- DMH Continuing EPSDT Oversight Activities; and
- New Targeted DMH Strategy to Monitor EPSDT Utilization for FY 2001-02 and Future Years.

DMH Program Compliance staff conducted field reviews of the EPSDT benefit during the first six months of FY 2001-02. One hundred fifty EPSDT client charts were selected at random from eleven MHPs. Reviewers found appropriate documentation of medical necessity in all of the charts examined and reported that, in 143 of the 150 charts, services provided to the clients by the MHPs were sufficient to meet the clients' needs. Reviewers identified a need for training MHP staff on documentation standards for treatment planning and progress notes. Program Compliance Division is working with the DMH Medical Director to develop a training program to address this area of deficiency. The EPSDT report was completed by DMH and submitted to the legislature April 2002. A copy was provided to CMS. Additional copies will be provided upon request.

For the last three FYs, DMH has evaluated statewide EPSDT expenditure data to identify MHPs that appear to be particularly high or low utilizers of the EPSDT benefit. DMH staff contacted these MHPs for further explanations of their EPSDT utilization. MHPs have been able to explain both high and low utilization. MHPs with low utilization proposed reasonable plans for future expansion. The process, however, suggested that DMH should develop criteria that would result in a more focused review.

Beginning in FY 2001-02, DMH initiated more complex analyses of selected MHPs in order to obtain a greater understanding of utilization and cost effectiveness of the EPSDT benefit at the local level. This analysis explored a variety of factors that impact EPSDT utilization and costs, such as county demographic information, severity and intensity data, availability of resources, and outcome data. MHPs selected for this in-depth analysis are those in which FY 2000-01 paid claims total per unduplicated client were 20 percent or higher than FY 1999-00 and the total of unduplicated clients had grown four percent or less during the same period. **APPENDIX IV C-1-b** is the detailed report of findings and follow up for FY 2000-01.

DMH is currently continuing the following measures to enhance EPSDT oversight activities, while we explore additional options:

- Follow-up on EPSDT field audits, including plans of correction, disallowances, and technical assistance and training;
- Intensive follow-up of MHPs in which claims have consistently been either greater than double or less than half the statewide rates for paid claims per average monthly eligible beneficiary;

c) DHS Oversight of DMH, the MHPs, and Providers

DHS has delegated the responsibility for oversight of MHPs and their provider networks to DMH via interagency agreement and does not plan to do on-site reviews of these entities. DHS monitors DMH for compliance with the terms of the interagency agreement, primarily through review of information compiled by DMH through its oversight efforts. DHS has also participated on some of the DMH reviews. DHS reviews and must approve waiver-related documentation prepared by DMH for consistency with Medi-Cal policy, including waiver renewal requests, DMH regulations and DMH Letters that address Medi-Cal policy issues. DHS liaison staff are in frequent contact with DMH staff on a variety of day-to-day waiver-related issues. DHS has the authority to perform reviews of DMH as appropriate. The state-level oversight process is described generally in the regulations in Title 9, CCR, Section 1810.380 (see **EXHIBIT 4**).

2. A grievance system will be continued under the third waiver renewal period. Beneficiaries will also have a right to a fair hearing as described in 42 CFR Part 431, Subpart E.

3. Beneficiaries were notified regarding the availability of psychiatric inpatient hospital services under the initial waiver program and were notified regarding the availability of the specialty mental health services when services were expanded in the first waiver renewal period. Beneficiary notification will continue to be provided under the third renewal period in the same manner as they are provided currently through August 2003, when the new requirements of Title 42, CFR, Part 438, will be in place.

4. MHPs will continue to monitor access trends through the Quality Improvement (QI) Program component of their Quality Management Programs. The MHP standards for Quality Management Programs are established in Title 9, CCR, Section 1810.440, and in the contracts between DMH and the MHPs (**EXHIBIT 3** and **EXHIBIT 4**). The QI standards were originally developed using 1996 National Committee for Quality Assurance (NCQA) standards for behavioral

health care organizations as a basis. Through the public planning process, the State modified these standards to be more inclusive of clients and family members and reflect public mental health practice in California. NCQA standards and the State's standards require that a licensed mental health staff person have substantial involvement in QI program implementation. NCQA also specified that plan practitioners and providers actively participate in the planning, design and execution of the QI program. California has modified this standard and included clients and family members in that role within the QI program. The State believes that using these generally accepted industry standards has minimized additional requirements and has been accepted and successfully utilized by MHPs. The State believes the MHP Quality Management Program requirements are consistent with the requirements of Title 42, CFR, Part 438, with some additional reporting from the MHPs. The State will continue to review the new requirements to ensure compliance.

5. At the State level, the State Quality Improvement Council (SQIC) was established by DMH in May 1999 to address system-level quality issues for specialty mental health services under the waiver. A membership list included as **APPENDIX IV-C-5**. Current membership includes a variety of stakeholders, including current and former mental health directors; clients, family members; key DMH administrative, multicultural services and medical staff; public at-large members, and county mental health staff. The SQIC considered ethnic, age and geographic demographics when selecting its membership to ensure that the membership would be fully representative. The SQIC meets a minimum of four times a year. Its mission is to assure a collaborative, accessible, responsive, efficient and effective mental health system that is culturally competent, client and family oriented and age appropriate by the implementation of quality improvement methodologies. DHS has decided not to participate in the SQIC as a member, because DHS sees the work of the various committees established by DMH for the administration of the waiver as falling within the delegated duties of DMH pursuant to the DHS/DMH interagency agreement (**EXHIBIT 1**). DMH routinely provides updates and copies of all SQIC actions to DHS.

   The State Budget Act signed in 2000 required the SQIC to develop a performance measurement system and expanded its responsibilities to include the entire public mental health system in California as well as the Medi-Cal program. The first quality issues considered by the SQIC were those highlighted by the independent assessment of the waiver program completed in August 1999 by IDEA Consulting, Inc.

   In order to pursue the in-depth quality studies, the SQIC established two workgroups – the Inpatient Treatment Review Workgroup in 2000 and the

Community Mental Health Services (Outpatient) Workgroup in 2001. These workgroups meet four to six times a year in Sacramento. In addition, the SQIC utilizes the expertise of other DMH advisory and support groups to expand its expertise and leverage resources. The DMH Cultural Competence Advisory Committee, the Client and Family Member Task Force, the CAC, and the Ombudsman Services Office all assist the SQIC on an issue-specific basis. **EXHIBIT 7** is a copy of the report prepared by DMH and submitted to the Legislature pursuant to Chapter 93, Statutes of 2000, which recognized the SQIC in law and required the report.

The SQIC adopted a performance measurement system of performance indicators and special studies. Indicators were selected to match as closely as possible other national indicator sets applicable to mental health (SAMHSA 16 State Indicator Pilot, NASMHPD Framework, Medicaid HEDIS, etc.). DMH SQIC staff also attended the CMS-sponsored Medicaid quality improvement conference in St. Louis. This provided the necessary technical assistance and training to allow DMH to formulate a performance

measurement system quite similar to that envisioned by the new Medicaid managed care regulations.

Indicators and special studies were established in four domains: Structure, Access, Process and Outcomes. Initially, the principal data source utilized was Medi-Cal paid claims. Recently, the Client Information and Services (CSI) database has become fully operational and is providing additional critical information for SQIC consideration. The CSI database includes both Medi-Cal and non-Medi-Cal clients of the public mental health systems and provides information that is not available from the SD/MC claiming system, e.g., the legal status of the client.

The SQIC formulated a variety of special studies in order to investigate critical parameters of care for which performance measures and data sources were not readily available. For example, two of the issues identified by the independent assessment of the waiver program in 1999 (rehospitalization rates and various disparities in treatment utilization by different racial and ethnic groups) were designated as special studies. These are discussed in further detain in the Section IV.D.5. below.

The SQIC will continue to study data and information that relate to the performance measurement system. In addition, the following are priorities for the FY 2002-03:

- Synthesis and possible integration of the recommendations and aims from the Institute of Medicine's "Crossing the Quality Chasm" study into DMH

performance measurement.

- Implementation of Title 42, CFR, Part 438, Subpart D, of the new Medicaid managed care regulations on Quality Assessment and Performance Improvement.

- Integration of the recovery model including client and family member involvement in the mental health service delivery system

D. Monitoring Quality of Services

1. Standards for Monitoring Quality of Services

   The State monitors and assures quality of services under the waiver program, as well as the quality improvement and utilization management standards that are applicable to MHPs under the waiver, through the DMH annual review process and on-going monitoring by contract managers in the TAT Section. See Section IV.C.1. above for a detailed description of the process. Standards for the monitoring of quality of care by the MHP through a Quality Management Program are provided in the contract between DMH and the MHPs (see **EXHIBIT 3**, Exhibit A, Attachment 1, Appendices A and B).

2. Responsibility for Assuring Quality of Care

   The MHP has primary responsibility for assuring quality of care by the MHP. The State has established detailed requirements for the monitoring of quality by the MHP as described in the implementation plan requirements (**EXHIBIT 5**). These requirements are also included in state regulations (see **EXHIBIT 4**, Title 9, CCR, Section 1810.440) and in the contract between DMH and each MHP (**EXHIBIT 3**). These requirements were based on the NCQA draft accreditation standards for managed behavioral health care organizations, adapted to make them more compatible with public mental health issues, as described in Section IV.C.4 above. MHPs describe county-specific quality management processes in their implementation plans. Compliance is verified by DMH through annual reviews that utilize a protocol with specific standards for access and quality and through ongoing monitoring activities as described above under Section IV.C.1. above. Additional steps have been taken through SQIC to identify quality of care issues and workgroups have been developed to address issues in both inpatient and outpatient systems.

3. Annual Beneficiary Grievance Reports

MHPs are required to submit an annual report to the State regarding beneficiary grievances, which is used by the State identify and analyze to trends grievances as part of the State's oversight efforts. Please refer to **APPENDIX IV-B-1**, which provides a summary of the grievance reports. If on-going monitoring efforts indicate a potential problem, TAT staff are also able to review grievance logs and files on-site at the MHP as a part of any necessary investigation. TAT staff coordinate with Program Compliance Division staff in the event there are significant issues which may require focused reviews or additional attention during the annual reviews.

4. Provider Credentialing

State standards for credentialing providers require the MHP to verify that providers are appropriately licensed and in good standing with the Medicare/Medicaid program and that the provider maintains a safe facility, stores and dispenses medications according to state and federal requirements and maintains client records that meet state and federal requirements. All providers must agree to comply with the quality management standards of the MHP and meet any additional requirements established by the MHP. Independent practitioners must be licensed to practice psychotherapy independently. Traditional SD/MC clinics must also have accounting/fiscal practices that meet state standards and have a head of service who meets state regulatory requirements. The requirements for MHP provider selection criteria are described in Title 9, CCR, Sections 1810.430 and 1810.435 (see **EXHIBIT 4**), although MHPs may set higher standards. Most MHPs have established credentialing requirements for their independent practitioners that follow NCQA credentialing standards and have reciprocal arrangements with other MHPs using the same standards.

5. Data Analysis

DMH has made considerable progress during the last two years in gathering and utilizing Medi-Cal claims data to monitor quality of services and access to services. This data has been used to support the reports and studies described below.

Mental Health Services in California

The DMH Statistics and Data Analysis Section has completed two in-depth reports focusing on Medi-Cal trends and a third is in process. The first report, published in June 2001, is titled Medi-Cal Mental Health Services in California, Fiscal Year 1993-94 through 1997-98. This report shows the utilization of Medi-Cal specialty mental health services both prior to and subsequent to consolidation. The report presents a statewide analysis of the number of

Medi-Cal eligibles, persons who received mental health services, and costs by aid group, age group, gender, race/ethnicity, and type of service. Detailed data are also presented by region and for each county. The report is on the DMH website, http://www.dmh.ca.gov/SADA/default.asp (scroll down to "Medi-Cal Specialty Mental Health Services–Medi-Cal Trend Report for FY 1993-94 through 1997-98"). An update to this report is in process for FY 1998-99 and FY 1999-00. This report will have similar data but more detail by type of service. An update is currently in process and due to be completed FY 2002-2003.

Medi-Cal County Profile Reports on Specialty Mental Health Services

Much of the data that was used and continues to be used for the two reports noted above was presented in a different manner for each county's Medi-Cal County Profile Report on Specialty Mental Health Services. The development of these reports was supported by a grant from the federal Center for Mental Health Services. The purpose of the grant was to provide statistical support services to local mental health boards. The initial activities of the grant involved training local board members in the types of data available and how to use data to support local decision-making. The profile reports were the last product of the grant. The reports are individualized for each county and show Medi-Cal eligibles, clients, services, cost, and various calculations from those indicators, such as cost per client for the total and by type of service. These reports show the data for the county, the region, and the state total. The reports were designed as training tools for local board members, so rather than analyzing the data, the reports describe the data, i.e., its significance and what it might indicate. They provide several prompt questions for local board members to consider as they examine the data for their counties, such as, "Is the trend in your county similar to that for the region and state?" and "Does the trend reflect policy and program changes in your county?" The reports have been distributed at regional and statewide meetings of representatives of the local boards and have been extremely well received. The reports will be posted on the DMH website in FY 2002-03. Individual hard copies, which are county specific, are available upon request.

SQIC Data Analysis

The SQIC relies heavily on data to accomplish its goal of improving quality in the mental health service delivery system. Two prime examples of this are the Rehospitalization Rate Special Study undertaken by the SQIC Inpatient Treatment Review Workgroup and the Latino Underutilization Study undertaken jointly by the SQIC and the DMH Cultural Competence Advisory Committee.

Rehospitalization rates were identified as a potential problem in the 1999 independent assessment of the waiver program. The SQIC Inpatient

Treatment Review Workgroup, using Medi-Cal paid claims data, has analyzed this issue in depth. Initially, the workgroup looked at a variety of data at a state level to determine if there were correlations that might help determine causation. Data reviewed included the following:

- Rehospitalization rates within 0-30 days of discharge;
- Rehospitalization rates within 0-180 days of discharge;
- Contacts after discharge by age group, and ethnicity;
- Number of clients by number of admissions by age group, ethnicity, and diagnosis;
- Admissions by length of stay by age group, ethnicity, and diagnosis;
- Admissions, clients, and average number of admits per client by age group, ethnicity, and diagnosis; and
- Clients, dollars and units by service type by age group, ethnicity and diagnosis.

The next step was to enlist interested MHPs to assist with understanding critical factors at the local level. Comprehensive county-specific data was developed for a small number of MHPs. The workgroup is currently in the process of working with each MHP individually to analyze this information. A report on rehospitalization rates will be presented to the SQIC in September 2002. The rehospitalization data displayed in charts are included in **Appendix IV-D-5**. There are extensive data (approximately 115 pages in

length) organized by age, diagnosis and region that will be made available upon request.

Using Medi-Cal paid claims data, the SQIC analyzed Latino utilization of inpatient and outpatient services. Data analysis included the following:

- Penetration rates by race/ethnicity;
- Medi-Cal eligibles, clients, and clients per 1,000 eligibles by race/ethnicity, age and type and amount of service;
- Inpatient admissions by race/ethnicity;
- Attrition and retention rates by race/ethnicity; and
- Contacts after discharge by race/ethnicity.

Based upon this analysis, and in cooperation with the Cultural Competence Advisory Committee, the SQIC recommended to the DMH Director that contractual requirements for quality improvement for MHPs be changed so that increased emphasis could be directed to Latino underutilization as a quality improvement focus, which is in place for the FY 2002-03 contract year (see **EXHIBIT 3**, DMH/MHP contract, Exhibit A, Attachment 1, Section E).

Realignment Study and Report

Pursuant to Assembly Bill (AB) 328, Salinas, DMH was required, in collaboration with CMHDA and other relevant parties, to submit a report to the Legislature regarding the affects of realignment funding. Realignment refers to the State funding of county health, social service and mental programs through sales and motor vehicle tax revenues established in 1991. Realignment funds make up most of the state match required for services delivered under the waiver program. Although the results of the study are still in draft, some preliminary findings and data are available. Several separate programs, including the Medi-Cal program, were reviewed for this study, which analyzes data for one year prior to and several years subsequent to realignment. The final report will examine:

- The current structure and status of the financing of mental health services established by realignment in 1991;
- Changes in the current service delivery system of mental health programs that have occurred since 1991; and
- Trends in the financial status and service delivery systems within county mental health programs.

The information used in this study includes data from a wide variety of sources, including Medi-Cal data. Most of the sources include data for FYs 1990-91, 1993-94, 1996-97, and 1999-00. The report contains the following data elements:

- Population data by county from the Department of Finance population estimates;
- Population under 200 percent of the federal poverty level (FPL) by county;
- Number of licensed residential community care facilities and beds for selected facility categories by county provided by the Department of Social Services, Community Care Licensing Division;
- Number of clients served, units of service, units of time, and estimated gross cost by mode and service function by county and age group from the Client Data System for the first three years and from the Client and Service Information (CSI) system for the last year;
- Total number of unduplicated clients served in all services;
- Number of clients served, days, and estimated cost for persons in Institutions for Mental Diseases;
- Number of persons served, units of service, and amount paid or approved for the SD/MC system, the FFS/MC system, and Inpatient Consolidation system. The SD/MC data include services claimed and approved through the SD/MC system and submitted to DMH through the MHPs;
- Total units and gross cost by mode from the Cost Reporting/Data

Collection (CR/DC) system and the new County Financial Reporting System (CFRS);
- Total funds and revenue summary from the CR/DC and CFRS;
- Number of persons served, days, and estimated costs for patients on conservatorship in state hospitals from the state hospital Admission/Discharge/Transfer (ADT) system; and
- Realignment allocations.

Further detail about this study, including the data tables, is available on the DMH website, http://www.dmh.ca.gov/SADA/default.asp (scroll down to "DRAFT DATA FOR REALIGNMENT").

Cultural Competency

As part of their CCP requirements, MHPs are required to analyze their local Medi-Cal populations addressing specific population characteristics, including client race/ethnicity and language. DMH staff have developed county specific tables by race/ethnicity, language, age and diagnosis that provide data on the Medi-Cal eligible population as well as the Medi-Cal clients. These data are provided to the MHPs so that they can determine the differences in utilization patterns among specific Medi-Cal populations and address these differences in their programs.

DMH Information Technology

The DMH Information Technology (IT) has been developing and testing a Decision Support System/Management Information System (DSS/MIS) to facilitate ease of access to and retrieval of data by staff throughout DMH and by MHP county staff. As various IT projects are undertaken, they are designed with this structure in mind.

Performance Outcome Systems

California began implementation of the Children and Youth Performance Outcome System on April 1, 1998. County mental health departments, which are also MHPs, have been collecting data on the Child and Adolescent Functional Assessment Scale (CAFAS), the Client Living Environment Profile (CLEP), the Child and Behavior Checklist (CBCL), the Youth Self Report (YSR), and the Client Satisfaction Questionnaire (CSQ-8). Instruments have been administered to clients upon intake, annually and at discharge. County mental health departments have submitted summary information to DMH on a semi-annual basis. Data were submitted on 75,619 non-duplicated clients for calendar year 2000 and on 78,433 non-duplicated clients for calendar year 2001.

The Adult System began implementation on July 1, 1999. County mental health departments have been collecting data on the California Quality of Life (CA-QOL) or the Lehman's Quality of Life-Short Form (QL-SF), the Mental Health Statistics Improvement Program (MHSIP) Consumer Survey Short Form, and a face sheet that measures demographic and background data. Instruments have been administered to clients upon intake, annually and at discharge. County mental health departments have submitted summary information to DMH on a semi-annual basis. Data was submitted on 34,635 non-duplicated clients for calendar year 2000 and on 44,365 non-duplicated clients for calendar year 2001. A pilot was completed for the Older Adult System. Similar instruments to the Adult System have been recommended but implementation has not yet begun.

DMH staff completed a study in 2002 that re-examined the current methodology (administering instrumentation upon intake, annually and at discharge). Historical data indicated that most clients received a single performance outcome administration without any follow-up administration for longitudinal analysis, as most clients left service prior to their annual review. See http://www.dmh.cahwnet.gov/RPOD/PDF/Global-System-Issues.pdf for additional information. Due to this and other problems encountered in the use of the existing methodology, DMH has been examining alternative methodology options. In collaboration with the California Mental Health Planning Council and CMHDA, DMH is considering an alternative methodology in which instruments would be administered to all clients receiving face-to-face services, excluding crisis services, during a one-week sampling period, every six months.

In addition, with the completion of a pilot of alternative instruments for the Children and Youth System and the completion of the Older Adult pilot, alternative instruments are under consideration for future use in the DMH performance outcome system. For example, the CSQ-8 may be replaced with the Youth Services Survey (YSS) for youth to complete and the Youth Services Survey for Families (YSS-F) for parents/caregivers to complete. Changes in instrumentation must be considered carefully as they would also require changes in technology systems. DMH has also been researching new technology options that might allow DMH to consolidate the data collection and management at DMH and remove the burden from county mental health departments of having to manage these data locally. DMH will continue with the collaborative process of refining the future performance outcomes system with the goals of increased system efficiency statewide and locally, more accurate and reliable data, reduced burden on county mental health departments and increased system flexibility for on-going revisions to enhance the system.

Additional detailed information on performance outcomes in the California public mental health system is available on the DMH website on the Internet at www.dmh.cahwnet.gov.

E. Clinical Indicators

A clinical record review for continuing medical necessity for psychiatric inpatient hospital services in county owned and operated hospitals is part of the psychiatric inpatient hospital services component of the review conducted by the DMH Program Compliance Division. Chart reviews are also conducted as part of the outpatient reviews for FY 2000-01and FY 2001-02. These reviews ensure medical necessity is documented. MHPs are required to establish clinical indicators of quality and access as a part of their Quality Management Programs (see **EXHIBIT 3**, Exhibit A, Attachment 1, Appendix A), subject to review by DMH. Disallowances are taken in both inpatient and outpatient services if medical necessity criteria are not documented.

F. Services Not Included

Services not covered under the waiver will be obtained in the same manner as under the regular Medi-Cal program. Medi-Cal beneficiaries will be informed of the services not covered under the waiver and the process for obtaining such services as part of the normal Medi-Cal eligibility determination process and/or the member information systems of the Medi-Cal managed care program. Medi-Cal services not covered by MHPs will be obtained under the same state system currently in place to deliver Medi-Cal services, which include various Medi-Cal managed care programs and the FFS/MC system. Beginning August 2003, based on the new Medicaid managed care regulations, MHPs will also need to include basic information on these services in their beneficiary brochures.

Physical health care services are not covered by the waiver program, including physical health care based treatment of mental illness. Current health care literature supports the fact that a significant amount of mental health service, usually medication treatment, is provided in physical health care settings, most often by PCPs. In planning for consolidation, one of the concerns expressed by both physical health care providers and MHPs was that the current, appropriate treatment of mental health issues that occur in physical health care should continue to be provided in these settings. Another concern expressed included the fact that health care plans, often capitated, may have new incentives to shift these costs to MHPs. This item was included in the State's medical necessity criteria (see **EXHIBIT 4**, Title 9, CCR, Section 1830.205 for the applicable medical necessity criteria) to ensure that current levels of physical health care based mental health treatment are maintained. The state funds allocated to MHPs for

accepting responsibility for specialty mental health services under the waiver did not include funds for services historically provided by physical health care providers.

MHPs are not generally responsible for treating substance abuse and antisocial personality disorders, whether the beneficiary has a single or a dual diagnosis. Treatment of beneficiaries for these diagnoses remains in the regular Medi-Cal program. Specialty mental health services for Medi-Cal beneficiaries with substance-related disorders and antisocial personality disorders are covered under the waiver if the beneficiary also has an included mental health diagnosis and the focus of the proposed intervention is treatment of the included mental health diagnosis. Personality disorders other than antisocial personality disorders are included mental health diagnoses. For EPSDT-eligible children who have a substance abuse disorder and an included mental health diagnosis, MHPs may treat both conditions. Treatment of the substance abuse disorder, however, is not included under the waiver. EPSDT-eligible beneficiaries are free to seek treatment of the substance abuse disorder outside the MHP.

Outpatient specialty mental health services and professional services provided to beneficiaries in nursing facilities needed to treat a diagnosis excluded from coverage by the MHPs are not included in the waiver. Services provided by FQHCs, Indian Health Centers, and Rural Health Clinics are not included in the waiver. See **EXHIBIT 4**, Title 9, CCR, Section 1810.355, for a more complete listing of excluded services.

V. Cost Effectiveness

A. General

The Medi-Cal Specialty Mental Health Services Consolidation waiver program was approved for a two-year renewal period effective November 20, 2000 and ending November 19, 2002. Cost effectiveness documentation if provided for the period November 20, 2000 through November 19, 2002 (the past two years under the program) and projected from November 20, 2002 and ending November 19, 2004 (the two-year renewal period). **Table 1** and **Table 2**, at the end of this section, show actual and estimated total costs, cost per member per month (PMPM), and percent change in cost PMPM without the waiver and under the waiver, for all Medi-Cal specialty mental health services included in the waiver, by Medi-Cal aid code group. These two tables are referenced throughout the remainder of this cost effectiveness section.

Beginning in FY 1995-96, county mental health departments received SGFs as the Medi-Cal match for increases in EPSDT services, other than psychiatric inpatient hospital services, over their prior year level of county funding (EPSDT baseline). Table 3, below, shows actual EPSDT claims for FY 1995-96 through FY 2000-01. Table 3 shows the baseline claims, the additional amount above the baseline claims, and the total EPSDT claims.

Table 3
Actual EPSDT Claims
(FFP and State Match)

	Fiscal Year					
	95-96	96-97	97-98	98-99	99-00	00-01
Baseline EPSDT	$107,579,925	$107,579,925	$107,579,925	$110,592,163	$117,241,088	$120,523,838
Additional EPSDT	26,892,070	62,064,461	110,337,927	184,304,326	273,338,411	392,019,829
Total EPSDT	$134,471,995	$169,644,386	$217,917,852	$294,896,489	390,579,499	$512,543,667

The costs of these increased services to children under 21 years of age would have been incurred without the waiver as SD/MC rehabilitative and case management services. Thus, the cost of EPSDT services are expected to be the same under the waiver as without the waiver and are shown as equal throughout this cost effectiveness documentation. Although the augmentation is assumed to be the same under the waiver and without the waiver, the actual funding level of augmented services will not be capped under the waiver.

B. Methodology and Calculations to Determine Savings for the Past Two Years of the Waiver Program

Table 4 shows the nomenclature used in the Cost Effectiveness Section.

Table 4

	Cost Effectiveness for Wavier Renewal
Year 1 of the Current Waiver	Last 7 months of FY 2000-01 and first 5 months of FY 2001-02
Year 2 of the Current Waiver	Last 7 months of FY 2001-02 and first 5 months of FY 2002-03
Year 1 of the Waiver Period	Last 7 months of FY 2002-03 and first 5 months of FY 2003-04
Year 2 of the Waiver Period	Last 7 months of FY 2003-04 and first 5 months of FY 2004-05

1. Costs Without the Waiver for the Past Two Years of the Program

Table 5, on page 60 below, shows annual costs without the waiver for the two-year waiver renewal period. The direct service costs in Table 5 are based on estimated payments developed from historical trends (and shown in **Table 1** at the end of this section). Actual data for FFS/MC inpatient and professional services and SD/MC inpatient and case management and rehabilitative services from FY 1991-92 through FY 1993-94 were used to develop estimated payments for FY 1994-95 through FY 2004-05 for each service type and Medi-Cal aid code group. In general, it was assumed that an inverse exponential relationship existed in the costs PMPM rather than a linear relationship, primarily due to resource constraints on the service delivery system. Thus, estimated costs PMPM were assumed to change at a decreasing rate. The method of least squares was applied to the actual costs PMPM for each service type and Medi-Cal aid code group to develop the best estimates of future year costs PMPM. **Attachment 1**, at the end of this section, provides an illustration of the inverse exponential relationship used to estimate FFS/MC inpatient disabled costs PMPM.

This methodology is similar to the approach previously used to estimate costs without the waiver. However, it is a more formalized approach and resulted in slightly different costs without the waiver when compared to previous waiver cost effectiveness documents. Also, the number of Medi-Cal beneficiaries changed which impacted costs without the waiver relative to prior waiver cost effectiveness calculations.

The EPSDT payments reflect actual additional costs due to the expansion of the EPSDT program. These costs were not included in historical data from which the trends without the waiver were developed. As a result, these costs are shown separately. Excluded from the EPSDT costs are the costs of services managed through the Administrative Services Organization (ASO). These costs are a direct result of the waiver and, as such, were removed from the Upper Payment Limit (UPL) and only included in costs under the waiver.

Historically, administrative costs have approximated eleven percent of direct service costs in the SD/MC program. These administrative costs reflect costs incurred by the MHP in administering the mental health program and include such things as countywide cost allocations (A-87 costs) and MHP administration costs. All costs incurred in MHP-owned mental health clinics are not reported as administration. Administrative costs without the waiver were assumed to continue to equal to eleven percent of the SD/MC direct service costs.

Utilization review costs were not previously included in the waiver cost effectiveness calculations because these costs are the same without and under the waiver. These costs were included in this waiver submittal in order to reflect the total Medi-Cal costs without and under the waiver. Actual utilization review costs were available through FY 2000-01 and were estimated for FY 2001-02 through FY 2004-05 assuming a linear growth in cost PMPM as shown in Table 1.

Medi-Cal Administrative Activity (MAA) costs reflect activities not included under county administration such as Medi-Cal outreach, Medi-Cal eligibility intake, crisis referral, and program planning. These costs differ from MHP administration in that most of these costs are incurred in an MHP-owned mental health clinic. Actual MAA costs were available for FY 1996-97 through FY 1999-00. MAA costs PMPM increased slightly from FY 1996-97 to FY 1998-99 then had a dramatic increase in FY 1999-00. Some of the increase in FY 1999-00 may be attributable to the waiver. However, without additional county-specific data it is not known to what extent the waiver impacted these costs. Thus, the linear trend in cost PMPM seen from FY 1996-97 through FY 1998-99 was applied to the FY 1999-00 cost PMPM to estimate cost PMPM in FY 2000-01 through FY 2004-05.

Table 5
Total Medi-Cal Payments for Specialty Mental Health Services
Without the Waiver
(FFP and State Match)

	Year Under Waiver	
	First Year	Second Year
FFS/MC		
Inpatient	$276,704,022	$295,995,759
Psychiatrist/Psychologist	29,940,713	29,878,414
SD/MC		
Inpatient	77,892,945	79,796,813
Rehab/Case Mgmt.	595,875,722	665,563,507
Additional EPSDT (1)		
Total Additional EPSDT	440,285,093	535,652,154
Less: ASO EPSDT	-2,297,559	-3,319,158
Net Additional SD/MC EPSDT	437,987,534	532,332,996
Total Direct Service Costs	$1,418,400,936	$1,603,567,489
Administrative Costs	122,545,914	140,911,372
Utilization Review Costs	10,186,416	11,749,173
Medi-Cal Administrative Activities (MAA) Costs	27,441,106	29,690,873
Total Costs Without the Waiver	$1,578,574,372	$1,785,918,907

(1) Additional EPSDT claims are above the baseline claims that are not reflected in historical trend data.

2. Actual Costs Under the Waiver for the Past Two Years of the Program

Table 6, on the next page, shows the actual and estimated costs under the waiver for the two-year waiver period. Actual costs under the waiver program are available for FY 2000-01, which represents seven months of the first year of the waiver. Costs under the waiver program for the last five months of the first year and all of the second year are not available and were estimated based on historical trends in costs PMPM for each service type, by Medi-Cal aid code group. Costs PMPM were assumed to reflect an inverse exponential relationship as was assumed without the waiver. Actual costs PMPM from FY 1995-96 (the first full FY after implementation of the initial Medi-Cal inpatient consolidation waiver) through FY 2000-01 were used to estimate FFS/MC inpatient and SD/MC inpatient costs PMPM, by Medi-Cal aid code group. Actual costs PMPM from FY 1998-99 (the first full FY after implementation of the Medi-Cal specialty mental health consolidation waiver) through FY 2000-01 were used to estimate SD/MC case management and rehabilitative costs PMPM, by Medi-Cal aid code group. **Table 2** at the end of the section provides the trends in total costs, cost PMPM, and percent

change in cost PMPM used for FFS/MC inpatient services, FFS/MC professional services, SD/MC inpatient services, and SD/MC rehabilitative/ case management services under the waiver.

Administrative costs are estimated at eleven percent of direct SD/MC costs based on actual historical administrative costs. The additional EPSDT costs are the same without and under the waiver, as are the utilization review costs. MAA costs were estimated assuming a linear growth in actual cost PMPM from FY 1996-97 through FY 1999-00 as shown in **Table 2**. ASO administrative costs were estimated based on the number of transactions forecast by CMHDA. These costs are assumed to be a direct result of the waiver and are included as costs under the waiver.

Table 6
Total Medi-Cal Payments for Specialty Mental Health Services
Under the Waiver
(FFP and State Match)

	Year Under Waiver	
	First Year	Second Year
FFS/MC		
Inpatient	$122,216,207	$130,775,212
Psychiatrist/Psychologist (1)		
SD/MC		
Inpatient	78,775,120	79,787,104
Rehab/Case Mgmt.	611,136,118	667,705,403
Additional EPSDT (2)		
Additional SD/MC EPSDT	437,987,534	532,332,996
ASO EPSDT	2,297,559	3,319,158
Total Additional EPSDT	440,285,093	535,652,154
Total Direct Service Costs	$1,252,412,538	$1,413,919,873
Administrative Costs	122,774,381	141,145,913
Utilization Review Costs	10,186,416	11,749,173
Medi-Cal Administrative Activities (MAA) Costs	28,507,466	33,772,386
ASO Administrative Costs	638,188	842,031
Total Costs Under the Waiver	$1,414,518,989	$1,601,429,376

(1) Included under SD/MC Rehab./Case Mgmt. Services
(2) Additional EPSDT costs are the same under the waiver as without the waiver.

3. Program Savings

Table 7, below, shows how total program savings were calculated under the waiver program.

Table 7
Total Program Savings Under the Waiver
(FFP and State Match)

Year	Costs Expected Without the Waiver	Actual Costs Under the Waiver Program*	Total Benefit Savings
First Year	$1,578,574,372	$1,414,518,989	$164,055,383
Second Year	1,785,918,907	1,601,429,376	184,489,531
Total	$3,364,493,279	$3,015,948,365	$348,544,914

* Second year costs are estimated.

C. Methodology and Calculations to Project Savings for the Two-Year Renewal Period

The two-year requested renewal period under this waiver is from November 20, 2002 through November 19, 2004. This period encompasses the last seven months of FY 2002-03, all of FY 2003-04, and the first five months of FY 2004-05. Costs are projected without the waiver during this two-year period and under the waiver for the two-year period.

As discussed previously, **Table 1** and **Table 2**, at the end of this section, provide the estimated total costs, cost PMPM, and percent change in cost PMPM without the waiver and under the waiver, for all Medi-Cal specialty mental health services included in the waiver. Estimated costs without the waiver and under the waiver were developed based on the trends in historical and estimated cost PMPM, by service type and Medi-Cal aid code group, assuming inverse exponential growth relationships and applying the method of least squares. Estimated costs PMPM were applied to estimated Medi-Cal beneficiaries to estimate total costs for each service type and Medi-Cal aid code group. DHS provided the estimated Medi-Cal beneficiaries shown in **Table 1** and **Table 2** through FY 2000-01. Medi-Cal beneficiaries in FY 2001-02 through FY 2003-04 were assumed to change based on the percentages provided by the DHS Fiscal Forecasting and Data Management Branch used to develop the Governor's May Budget Revision for FY 2002-03. FY 2004-05 Medi-Cal beneficiaries were assumed to change at the same rate as estimated in FY 2003-04.

1. Costs Without the Waiver for the Two-Year Renewal Period

   a) FFS/MC Psychiatric Inpatient Hospital Services

      FFS/MC psychiatric inpatient hospital services cost PMPM increased significantly from FY 1991-92 through FY 1993-94, but at a decreasing rate. Future year estimates in cost PMPM were assumed to continue the trend at a slower rate of growth until there is a slight decline in the later FYs.

   b) FFS/MC Other Specialty Mental Health Services

      Historical costs PMPM for FFS/MC professional services varied by aid code group. Trends in the Disabled and Other aid code groups declined during the three year period and estimated costs PMPM were assumed to continue to decline. Costs PMPM for the AFDC aid code group declined in FY 1992-93 then increased in FY 1993-94. Estimated costs PMPM were assumed to decline slightly each year for the AFDC aid code group. Overall, costs PMPM were estimated to decline slightly more than five percent during the waiver renewal period.

   c) SD/MC Psychiatric Inpatient Hospital Services

      Historical costs PMPM, by aid code group, for FY 1991-92 through FY 1993-94 for SD/MC inpatient hospital services were used to estimate costs PMPM during FY 1994-95 through FY 2004-05. Costs PMPM in two of the aid code groups (Disabled and AFDC) showed a continuing decline during FY 1991-92 through FY 1993-94, and were assumed to continue to decline through FY 2004-05. Costs PMPM for the Other aid code group increased during FY 1991-92 through FY 1993-94 at an average of slightly more than two percent per year. Costs PMPM for the Other aid code group were estimated to continue to increase between one to two percent per year through FY 2004-05.

   d) SD/MC Rehabilitative and Case Management Mental Health Services

      Trends in historical costs PMPM for SD/MC rehabilitative and case management services varied by Medi-Cal aid code group. Two of the aid code groups (Disabled and Other) increased significantly from FY 1991-92 through FY 1993-94. Estimated costs PMPM were assumed to continue to increase, but at a decreasing rate, for these two Medi-Cal aid code groups. Historical costs PMPM for the AFDC aid code group decreased in FY 1992-93 then increased in FY 1993-94, partially due to

the change in service delivery system from a clinic-based model to the current rehabilitative service delivery model. Estimated costs PMPM for AFDC were anticipated to increase, but at a relatively low growth rate of around one percent per year.

e) EPSDT Augmentation

As mentioned previously, beginning in FY 1995-96, county mental health departments receive SGFs as the state Medi-Cal match for increases in EPSDT services over their prior year level of county funding. The costs for these increased services to children under 21 years of age would have been incurred without the waiver as SD/MC rehabilitative and case management services. These costs are not incorporated into the historical SD/MC costs and, therefore, not trended for future FYs as part of the SD/MC costs.

The actual increase in SD/MC reimbursement attributable to the EPSDT program is shown in **Table 1** for FY 1995-96 through FY 2000-01. The actual cost PMPM for additional EPSDT services increased significantly during this time period but at a declining rate of increase. The cost PMPM was estimated to continue to increase, but at a declining rate of growth.

There are costs attributed to the ASO under the overall EPSDT costs. These costs are excluded from costs without the waiver because these costs are incurred as a direct result of the waiver. The amounts shown in **Table 1** were estimated by CMHDA using actual costs through most of FY 2001-02 and estimates based on projected number of transactions through FY 2004-05.

f) Administration

Administrative costs were included in reimbursement rates and not separated from direct services prior to FY 1994-95. Administrative costs without the waiver are estimated to equal 11 percent of the SD/MC direct service costs based on historical data.

g) Utilization Review

Actual utilization review costs were available for FY 1997-98 through FY 2000-01. A linear trend in cost PMPM using the method of least squares was assumed to continue through FY 2004-05. These costs are the same without and under the waiver.

h) Medi-Cal Administrative Activities (MAA)

Actual MAA costs were available for FY 1996-97 through FY 1999-00. The cost PMPM for FY 1996-97 through FY 1998-99 was used to estimate a linear trend in cost PMPM through FY 2004-05.

i) Total Medi-Cal Specialty Mental Health Services

The sum of FFS/MC inpatient and other specialty mental health services, SD/MC inpatient and rehabilitative and case management payments, the net additional EPSDT augmentation, administrative, utilization review, and MAA costs represents total Medi-Cal specialty mental health services appropriate for comparison to costs under the waiver. Table 8 below summarizes total estimated Medi-Cal specialty mental health services payments without the waiver for the two-year waiver renewal period (November 20, 2002 through November 19, 2004).

Table 8
Total Medi-Cal Payments for Specialty Mental Health Services
Without the Waiver
(FFP and State Match)

	Year Under Waiver	
	First Year	Second Year
FFS/MC		
Inpatient	$299,846,625	$303,533,926
Psychiatrist/Psychologist	28,982,927	28,218,827
SD/MC		
Inpatient	76,718,849	73,961,050
Rehab/Case Mgmt.	697,365,612	728,622,691
Additional EPSDT (1)		
Total Additional EPSDT	599,426,657	656,301,584
Less: ASO EPSDT	-4,623,593	-5,715,444
Net Additional SD/MC EPSDT	594,803,064	650,586,140
Total Direct Service Costs	$1,697,717,077	$1,784,922,634
Administrative Costs	151,086,223	160,477,386
Utilization Review Costs	12,372,517	13,024,080
Medi-Cal Administrative Activities (MAA) Costs	31,325,156	33,034,044
Total Costs Without the Waiver	$1,892,500,973	$1,991,458,144

(1) Additional EPSDT claims are above the baseline claims that are not reflected in historical trend data.

2. Costs Under the Waiver for the Two Year Renewal Period

a) FFS/MC Psychiatric Inpatient Hospital Services

Overall, actual cost PMPM for FFS/MC psychiatric hospital inpatient services declined significantly during the first two full years of Medi-Cal inpatient consolidation (FY 1995-96 and FY 1996-97) and then remained relatively unchanged over the next four years (FY 1996-97 through FY 2000-01). Thus, the costs PMPM during the most recent four years of actual data were used to estimate the costs PMPM for FY 2001-02 assuming a linear relationship and using the method of least squares.

b) FFFS/MC Other Specialty Mental Health Services

Under the waiver, FFS/MC psychiatrist and psychologist specialty mental health services were combined with SD/MC rehabilitative and case management services under one service delivery program. Thus, the actual costs of FFS/MC psychiatrist and psychologist specialty mental health services for FY 1998-99 through 2000-01 are included with the SD/MC rehabilitative and case management costs and incorporated into the trend in costs PMPM.

c) SD/MC Psychiatric Inpatient Hospital Services

The actual costs PMPM for SD/MC psychiatric inpatient hospital services varied by aid code group. The cost PMPM for the Disabled aid code group declined almost every year and is estimated to continue to decline at about five percent per year based on applying a linear trend line to FY 1995-96 through FY 2000-01 costs PMPM. The cost PMPM for AFDC declined from FY 1991-92 through FY 1995-96, then increased significantly for a few years, and then decreased marginally. Future year cost PMPM are anticipated to continue to increase but at a slower rate of growth assuming a linear trend. The cost PMPM for the Other aid code group increased and decreased significantly from FY 1991-92 through FY 2000-01. Assuming a linear relationship and applying the method of least squares and assuming a linear relationship to FY 1995-96 through FY 2000-01 actual costs PMPM for the Other aid code group resulted in the cost PMPM decreasing from FY 2001-02 through FY 2004-05.

d) SD/MC Rehabilitative and Case Management Services

The costs PMPM of SD/MC rehabilitative and case management services has increased significantly over the years due primarily to (1) general growth in the program, (2) the switch from clinic-based services to rehabilitative services in FY 1993-94, (3) Medi-Cal inpatient consolidation in FY 1994-95, (4) EPSDT expansion in FY 1995-96, and (5) FFS/MC professional services consolidation in FY 1998-99. However, the rate of growth since FY 1998-99 has declined. The estimated costs PMPM for

FY 2001-02 through FY 2004-05 increase but at a decreasing rate (inverse exponential curve) and assume no major program changes.

e) EPSDT Augmentation

The additional EPSDT program expansion costs are included in SD/MC rehabilitative and case management services under the waiver and are incorporated into future year trends in Table 2. These costs are assumed to be the same under the waiver as without the waiver.

f) Administration

Administrative costs have equaled approximately 11 percent of the direct service costs of SD/MC services from FY 1995-96 through FY 2000-01. This ratio is estimated to continue through FY 2004-05.

g) Utilization Review

Utilization review costs are assumed to be the same without the waiver and under the waiver.

h) Medi-Cal Administrative Activities (MAA)

Actual MAA costs were available for FY 1996-97 through FY 1999-00. The cost PMPM for FY 1996-97 through FY 1999-00 was used to estimate the costs PMPM through FY 2004-05 assuming a linear trend. This is slightly different than costs without the waiver because this trend incorporated the significant increase in FY 1999-00 so that the difference in costs is attributed to the waiver.

i) ASO Administration

ASO Administrative costs are additional administrative costs that are incurred as a direct result of the waiver. These costs are estimated based on projected number of transactions developed by CMHDA.

j) Total Medi-Cal Specialty Mental Health Services

The sum of FFS/MC inpatient and other specialty mental health services, SD/MC inpatient and rehabilitative and case management payments, administration, utilization review, MAA, and ASO administration represents total Medi-Cal specialty mental health services covered under this waiver.

Table 9, on the next page, summarizes total estimated Medi-Cal specialty mental health services payments under the waiver for the two-year waiver renewal period.

Table 9
Total Medi-Cal Payments for Specialty Mental Health Services
Under the Waiver Program
(FFP and State Match)

	Year Under Waiver	
	First Year	Second Year
FFS/MC		
Inpatient	$133,440,519	$136,249,721
Psychiatrist/Psychologist [1]		
SD/MC		
Inpatient	77,202,952	74,875,193
Rehab/Case Mgmt.	686,509,490	690,898,179
Additional EPSDT [2]		
Additional SD/MC EPSDT	594,803,064	650,586,140
ASO EPSDT	4,623,593	5,715,444
Total Additional EPSDT	599,426,657	656,301,584
Total Direct Service Costs	$1,496,579,618	$1,558,324,677
Administrative Costs	149,945,301	156,428,246
Utilization Review Costs	12,372,517	13,024,080
Medi-Cal Administrative Activities (MAA) Costs	38,592,470	43,662,511
ASO Administrative Costs	896,541	792,149
Total Costs Under the Waiver	$1,698,386,447	$1,772,231,663

(1) Included under SD/MC Rehab./Case Mgmt. Services
(2) Additional EPSDT costs are the same under the waiver as without the waiver.

3. Program Savings During the Renewal Period

Table 10, below, shows how total program savings were calculated under the waiver program during the two-year renewal period. The waiver program is estimated to save approximately eleven percent over what costs would be without the waiver.

Table 10
Total Projected Program Savings Under the Waiver

Year	Costs Expected Without the Waiver	Actual Costs Under the Waiver Program	Total Benefit Savings
First Year	$1,892,500,973	$1,698,386,447	$194,114,526
Second Year	1,991,458,144	1,772,231,663	219,226,481
Total	$3,883,959,117	$3,470,618,110	$413,341,007